

SELF-ADMINISTRATION OF MEDICATIONS CONSENT FORM

My child requires medications during MNA programs. I will explain to my child the process and importance of self-administering medications while supervised by MNA staff. I understand and agree to the following terms and expectations:

1. Prescription medications must be delivered to MNA staff in original containers prepared by a pharmacist and include patient name, medication name, dosage, and time to be given. Only send the amount needed based on program length.
2. Over-the-counter medications must be in original packaging with directions, dosages, and contents, clearly marked. Only send the amount needed based on the length/duration of the program.
3. All medications must be accompanied by this completed and signed consent form.
4. Children are not allowed to keep any medications with them.
5. Parents must pick up all medications at the end of each program and deliver medications to the appropriate staff during subsequent programs. Medications that are not picked up at the end of each program will be discarded after two weeks.
6. MNA staff cannot force my child to take medications and can only facilitate the self-administration process. MNA staff is not liable if my child refuses to self-administer medications while supervised by MNA staff. If my child refuses to self-administer medications, while supervised by MNA staff, MNA staff will phone me. If I cannot persuade my child to take the medication during this call, I will pick up my child immediately, even if my child is on a field trip.

I ATTEST THE FOLLOWING MEDICAL DISCLOSURE IS TRUTHFUL AND COMPLETE AND I AUTHORIZE MNA STAFF TO ASSIST MY CHILD WITH SELF-ADMINISTRATION OF THE FOLLOWING MEDICATIONS

Medication Name #1 _____ Prescription? Yes/No

Dosage and Schedule: _____

Additional guidelines: _____

How long has your child been taking the above medication? _____

What condition does this medication treat? _____

What are the symptoms of this condition? _____

What side effects are or may be experienced from this medication? _____

If your child refuses to take the above medication, what will your child experience? _____

Should MNA staff know anything else about the above medication or your child's self-administration of this substance?

Medication Name #2 _____ Prescription? Yes/No

Dosage and Schedule: _____

Additional guidelines: _____

How long has your child been taking the above medication? _____

What condition does this medication treat? _____

What are the symptoms of this condition? _____

What side effects are or may be experienced from this medication? _____

If your child refuses to take the above medication, what will your child experience? _____

Should MNA staff know anything else about the above medication or your child's self-administration of this substance?

◆ Parent/Guardian Signature: _____ DATE: _____