

# MEDICATION AUTHORIZATION & RELEASE

Participant's Name \_\_\_\_\_

## Current Medications

1. Name of medication to be taken \_\_\_\_\_  
How often and when \_\_\_\_\_
2. Name of medication to be taken \_\_\_\_\_  
How often and when \_\_\_\_\_
3. Name of medication to be taken \_\_\_\_\_  
How often and when \_\_\_\_\_

Does participant need any assistance in taking this medication? Yes \_\_\_\_\_ No \_\_\_\_\_

## Allergies

Food \_\_\_\_\_

Medications \_\_\_\_\_

Other \_\_\_\_\_

**I give my permission for my child to have this over the counter medication as needed:**

**Acetaminophen (Tylenol)** \_\_\_\_\_ **Dose** \_\_\_\_\_

**Ibuprofen (advil/motrin)** \_\_\_\_\_ **Dose** \_\_\_\_\_

**Benadryl** \_\_\_\_\_ **Dose** \_\_\_\_\_

**Antacid** \_\_\_\_\_ **Dose** \_\_\_\_\_

**Dramamine** \_\_\_\_\_ **Dose** \_\_\_\_\_

**Other** \_\_\_\_\_ **Dose** \_\_\_\_\_

**Parent or legal guardian released Castleton United Methodist Church, staff, and members thereof, from any legal liability for harm resulting from administering the above medications.**

**Signature of Parent or Legal Guardian** \_\_\_\_\_

**Date** \_\_\_\_\_