

SACRED HEART YOUTH MINISTRY

Self-Administration of Medication

Permission for child/youth to carry and/or use emergency medication for potentially life threatening condition

Child's/Youth's Name: _____ DOB: _____

Parish: _____ City/Town: _____

HEALTH CARE PROVIDER:

Diagnosis: _____

Name of Medication: _____

Dosage of Medication: _____

Possible Side Effects: _____

I certify that the child named above has allergies that are potentially life-threatening, as listed above, and is permitted to self-administer the listed medication. The child has been instructed in the proper techniques of self-administration and has demonstrated to me competence in this technique.

Name of Health Care Provider (PRINT): _____

Signature of Health care Provider: _____

Address: _____

Phone: _____ Date: _____

PARENT/GUARDIAN:

I authorize my child to self-administer the listed medication during religious education hours, if necessary. I acknowledge the parish of _____ DOES NOT have a nurse OR trained staff member on the premises during religious education hours. In the event my child must self-administer epinephrine (EpiPen), I understand that 911 will be called and my child will be transported to the local hospital. It is my obligation to provide the Parish Youth Ministry Office with working telephone numbers where I can be reached at all times and my responsibility to attend to my child once the emergency squad leaves the parish program.

I understand that the Diocese of Metuchen, the parish of _____ and any and all of their representatives or agents shall incur no liability as a result of any injury arising from the self-administration of the listed medication. I will indemnify and hold harmless the Diocese of Metuchen, the parish of _____, and any and all of their representatives or agents against all claims arising from the self-administration of the listed medication.

Signature of Parent/Guardian: _____ Date: _____

Phone: _____ Cell: _____ **EFFECTIVE FOR ONE (1) YEAR**