

Authorization for Medical Treatment

PLEASE PRINT (*Update for each event requiring medication*)

Last Name _____ First Name _____ Middle Initial _____
Age _____ Date of Birth ___/___/___ Social Security Number _____
Home Street Address _____
City _____ State ___ Zip Code _____
Parent/Guardian Name _____
Relationship _____
Home Street Address _____
City _____ State ___ Zip Code _____
Home Number (____) _____ Work Number (____) _____
Mobile Number (____) _____ Pager Number (____) _____
Other Number (____) _____

PART I: Medical Consent (*Parent or Legal Guardian is required to complete*)

I certify that I am the parent, legal guardian, or other person in legal control of the above identified child and request and authorize that my child be administered appropriate first aid and/or taken to the nearest medical facility for emergency treatment as necessary.

Parent or Legal Guardian _____ Date _____

PART II: Permission to Use Over-the-Counter Medication (*If not completed, Young Marines will not receive medication*)

My child, _____, has my permission to take any over-the-counter medications in accordance with label instructions as needed with the exception of:
_____ while attending
Young Marine Activities.

Parent or Legal Guardian _____ Date _____

PART III: Permission to Dispense Prescription Medication (If not completed, Young Marines will not receive medication)

I request and authorize that my child, _____, be administered the following prescription medication:

_____ per the medical doctor's instructions on the original and un-expired pharmacy label. I certify that my child has a valid health reason for taking the medication during the Young Marine Activities. This permission is valid from (beginning date) _____ to (ending date) _____.

Parent or Legal Guardian _____ Date _____

PART IV: Medication Administration Record

Medication Name _____ Strength _____

Form of Medication: ___ Liquid ___ Tablet ___ Aerosol ___ Ointment ___ Other

Dosage & Time _____

Medication Name _____ Strength _____

Form of Medication: ___ Liquid ___ Tablet ___ Aerosol ___ Ointment ___ Other

Dosage & Time _____

Medication Name _____ Strength _____

Form of Medication: ___ Liquid ___ Tablet ___ Aerosol ___ Ointment ___ Other

Dosage & Time _____

Medication Name _____ Strength _____

Form of Medication: ___ Liquid ___ Tablet ___ Aerosol ___ Ointment ___ Other

Dosage & Time _____