

**NATIONAL YOUTH SPORTS PROGRAM  
MOREHOUSE COLLEGE**

**AUTHORIZATION TO GIVE MEDICATION AT NYSP**

If medication can be given at home or after camp, please do so. However, if medication must be given during camp hours, this form must be completed.

Student's Name: \_\_\_\_\_ Counselor: \_\_\_\_\_ Group: \_\_\_\_\_

I hereby request that the NYSP Nurse/Medical Coordinator or designee, supervise/assist in the administering of medication to my child, \_\_\_\_\_, according to the instructions contained on the statement below. I understand that:

- Medication (both prescription and nonprescription) must be in the original labeled container (no baggies, foil, etc.).
- Parent/guardian must provide specific instructions, as well as the medication and related equipment to the camp personnel.
- It will be the responsibility of the parent/guardian to inform the camp of any changes. New medication or new doses will not be given unless a new form is completed.
- All medication will be taken directly to the clinic by parent/guardian and/or student.
- Unused medication will be disposed of unless picked up one week after medication is discontinued.
- Camp employees will not assume any liability for supervising or assisting in the administration of medication.
- Aspirin can be given if needed

**Circle one:** Prescription or nonprescription (if prescription, have physician/health care provider complete and sign bottom portion).

**NAME OF MEDICATION:** \_\_\_\_\_

**DOSAGE/TIME OF ADMINISTRATION:** \_\_\_\_\_

**STOP MEDICATION ON:** \_\_\_\_\_

**PHYSICIAN'S NAME:** \_\_\_\_\_ **PHONE NUMBER:** \_\_\_\_\_

I RELEASE THE NYSP, the camp, and any camp employee from any liability for administering this Medication.

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**Required signature** of Parent(s)/Guardian(s) \_\_\_\_\_ Date \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Pager/Cell: \_\_\_\_\_

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**TO BE COMPLETED BY HEALTH CARE PROVIDER FOR PRESCRIPTION MEDICATIONS:**

**CONDITION/ILLNESS REQUIRING MEDICATION:** \_\_\_\_\_

**POSSIBLE SIDE EFFECTS, IF ANY:** \_\_\_\_\_

**SIGNATURE OF HEALTH CARE PROVIDER:** \_\_\_\_\_

**TO BE COMPLETED BY MEDICAL COORDINATOR/CAMP**

**RECEIVED DATE:** \_\_\_\_\_ **MEDICINE:** \_\_\_\_\_ **# OF DOSES:** \_\_\_\_\_