

ALATEEN MEDICATION AUTHORIZATION FORM FOR AFGG EVENTS

Date(s) of Event: _____

I understand that the purpose of this form is to allow a Designated Medical Administrator (DMA)* to administer medication to _____, an Alateen during the event taking place on the date(s) written above. I understand if there is a transporting AMIAS, he/she will be responsible for secure delivery of medication to the DMA. The Alateen has the condition(s) set forth below that require that he/she take the prescription and/or over-the-counter medication listed below. I hereby certify that the schedule below includes all medication to be administered to and taken by the Alateen during the event. I acknowledge and agree that the Alateen will not be administered any medication that is not contained in the list below, including over-the-counter medication in a typical first aid kit (e.g., Tylenol, aspirin, aloe vera gel, calamine lotion, anti-diarrhea medication, laxative, antacid, antihistamine, hydrocortisone cream, cough and cold medication), nor will any medication be given in any manner that contradicts the information set forth below. The DMA who administers the medication will keep all medication in its original, marked container, store it securely out of reach of other children, and administer the medication in the dosage and according to the schedule set forth below. I understand I am responsible for assuring that all medication is provided in its original container and – if a prescription – identified as to content, dosage and Alateen's name, and is not expired.

*A DMA is a healthcare professional licensed to administer medication and hired through an agency.

Medical Condition / Symptoms	Name of Medication	Expiration Date	Dosage (E.g., 1 tablet, 2 tsp)	When & How Often Dose is Administered (e.g., 1 daily at lunch)	Side Effects	Special Storage Requirements? (e.g., refrigerate)

Are there any emergency medications (e.g., life-saving medication that must be carried by the Alateen) needed by this Alateen? (Circle one) **Yes** **No**

If Yes, please list: _____

If a DMA or AMIAS has any questions or observes the Alateen having any allergic reactions or other side effects, the AMIAS will notify the DMA and the DMA will contact the parent/guardian. AMIAS will not administer medication to Alateens except in life-saving situations. If there is increased difficulty breathing or a significant injury, 911 can be called by anyone.

Signature of Custodial Parent/Legal Guardian: _____ Print: _____ Date: _____

_____ (Initial here) I understand that the accompanying AMIAS **CANNOT** administer routine medication to my teen. Emergency Phone #: _____

AMIAS Pre-Event Notes: _____

AMIAS/Emancipated Teen Signature: _____ Print: _____ Date: _____

This fully completed, signed form must accompany other required registration forms if medication is to be administered by a DMA. This form is to be submitted to the Registration Chair (Alternate Delegate at Assembly and AWSC) to scan electronically and the original delivered to the DMA. Upon event completion, the original form and any remaining medications will be returned to the authorized person or transporting AMIAS, who will return them to the custodial parent/legal guardian. The Registration Chair will send the scanned copy of this form to the AAPP for secure retention after the event. This form must be completed and signed in the presence of the AMIAS named above and may not be altered after being signed by the custodial parent/legal guardian.