Authorization for Athletes that will be taking their own medication

By signing this document I agree that JCPRD Staff will be distributing medications for my athlete.

Parent/Guardian: _____ Date: _____

Athlete: _____ Date: _____

*Please check if athlete is able to take Tylenol if needed? ☐ Y or ☐ N

*Does athlete have seizures? ☐ Y or ☐ N

Complete Contact Information below:

List two different contacts in case of emergency.

First Contact:

Name _____

Phone Number _____

Second Contact:

Name _____

Phone Number _____

Please Fill Out Below:

What time of day does the athlete take medications? Fill in the name of the medication underneath each corresponding time.*Must be filled out on this sheet, not a separate sheet.

8am	Noon	5pm	9pm
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

NOTE: Please package medications according to date and time.
Each package needs to be labeled with date, athlete name, name of medication, time & dosage
Place all packages in a zip lock baggie