Authorization for Athletes that will be taking their own medication

By signing this document I agree that my athlete is responsible for taking his/her medications.

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 _____