CATHOLIC DIOCESE OF EVANSVILLE
SOURCE + SUMMIT RETREAT
AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY AUTHORIZED PERSONNEL

I HEREBY AUTHORIZE PERSONNEL TO ADMINISTER MEDICATION AS INDICATED TO:

Name: ______________________________Grade _____ Youth Minister _________________________

Rx Number: _________________________ Name of Medication: ______________________________

Directions: ____

Doctor: ____________Phone: ___________Pharmacy: ____________________Phone:_______________

Time(s) medication is given at home: ___________________

Time(s) medication is to be given at the event: ____________

I UNDERSTAND THAT MY SIGNATURE RELIEVES THE PARISH PERSONNEL OF ANY AND ALL LIABILITY RELATED TO THE ADMINISTRATION OF THE PRESCRIBED MEDICATION.

Signature of Parent/Guardian X______________________________Date: _________________

Phone number where you may be reached during the event: _________________________