Delta Sigma Theta Sorority, Inc. ~ Tempe Alumnae Chapter

Medication Authorization

Name of Minor _____ DOB _____

Medication _____

Dosage _____

Time of Administration _____

Reason for Medication _____

Possible side effects and significant information _____

_____

_____

Physician's Signature _____

Physician's Printed Name _____

Physician's Phone Number _____

Parental Authorization

I/We hereby give permission for my/our daughter, _____, to take medication as indicated by the physician above. I/We understand that it is my/our child's responsibility to report to a program volunteer at the appropriate time for the administration of the medication. I/We further understand that it is our/my responsibility to furnish this medication and any authorized refills. I/We further understand that Delta Sigma Theta Sorority, Incorporated ("Delta"), its officers, National Executive Board, employees, members, local chapters, representatives, agents, affiliates, or volunteers who administers any drug to my/our child, in accordance with written instructions from the prescriber, shall not be liable for damages as a result of an adverse drug reaction or any other injury suffered by my/our child due to the administration or failure to provide the drug.

Delta reserves the right to refrain from administering medication if in the judgment of Delta, or other authorized program officer, agent, employee, or volunteer, the circumstances do not warrant medication administration.

I/We understand that the medication must be brought to the Dr. Betty Shabazz Delta Academy or Dr. Jeanne L. Noble Delta GEMS Youth Institute by me/us in the original appropriately labeled container. If I/we cannot bring the medication, I/we will call the program contacts to inform them that my/our child will be bringing it, indicated the amount of medication in the container.

Parent Name: _____

Signature:_____ Date: _____

Parent Name: _____

Signature:_____ Date: _____