WOODLAND PARK JR. WRESTLING CLUB
MEDICATION ADMINISTRATION AUTHORIZATION FORM
PO BOX 7005 WOODLAND PARK, CO 80863

I. INSTRUCTIONS

Please complete this form in its entirety. For your child to have medication at practice/tournaments please make sure that medications:

- **Are in the original container labeled by the pharmacist or prescriber.**
- **Nonprescription medication is in the original container with instructions on them. Nonprescription medications include: vitamins, homeopathathic, and herbal medications.**
- **One form per medication needed**

II. CLUB INFORMATION

YOUTH SPORT CLUB: Woodland Park Jr. Wrestling Club		
PRACTICE ADDRESS: 151 Panther Way		
CITY: Woodland Park	**STATE:** CO	**ZIP CODE: 80863**

III. PRESCRIPTION/PROVIDER INFORMATION

CHILD'S NAME:	**DATE OF BIRTH:**	
CONDITION FOR WHICH MEDICATION IS BEING ADMINISTERED:		**EMERGENCY MEDICATION** ☐ **YES** ☐ **NO**
MEDICATION NAME:	**DOSE:**	**ROUTE:**
TIME/FREQUENCY OF ADMINISTRATION:		**IF PRN, FREQUENCY:**
IF PRN, FOR WHAT SYMPTOMS:		
KNOWN SIDE EFFECTS SPECIFIC TO CHILD:		
MEDICATION SHALL BE SELF-ADMINISTERED **Note: Coaches cannot administer medications unless it is a life threatening situation. Your child will need to self-administer, or you will need to be present to administer the medications to your wrestler due to liability to the Club**		**INITIAL HERE**
PRESCRIBER'S NAME/TITLE		
TELEPHONE:	**ADDRESS:**	
Please attach copy of completed Medication Administration form from your school if one is on file		

IV. PARENT/GUARDIAN AUTHOIRZATION

I authorize Woodland Park Jr. Wrestling Club Coaches/staff to supervise the self-administration of the medication listed above as prescribed by the above provider. I authorize Woodland Park Jr. Wrestling Club Coaches/Staff to administer the medication if it is in a life-saving effort to prevent death and release the coaches/staff from any and all liability associated with the administration of said medication. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of medication. I understand that this form is only valid for the authorization period listed above. I authorize coaches/staff to communicate with the prescriber as allowed by HIPPA in the event of an emergency. I confirm that, if the medication above is a prescription medication, the child has at some point taken the medication prior to attending our club.

PARENT/GUARDIAN SIGNATURE:	**DATE:**
HOME PHONE #:	**CELL PHONE #:**

V. VERIFICATION OF MEDICATION PICK-UP/RETURN

MEDICATION PICKED UP/RETURNED TO PARENT: **YES** **NO**	**PARENT SIGNATURE:**	**DATE:**
WPJWC STAFF MEMBER/COACH SIGNATURE:		**DATE:**