NORTH FLORIDA GYMNASTICS & CHEERLEADING
MEDICATION AUTHORIZATION FORM

Participant Name_____ Male or Female

D.O.B._____/_____/_____ Age_____ Weight_____ Allergies_____

Name of Medication_____

Prescription or Over the counter?_____ Should it be Refrigerated?_____

Dosage_____ How taken (mouth, inhaled, etc.)_____

When to dispense medication (daily, when needed, etc.)_____

Purpose of Medication_____

Special Instructions_____

Possible side effects to be aware of_____

Start Date_____ End Date_____

Child's Physician_____ Phone_____

I hereby give permission for my child (Participant Name), _____, to receive the above medication, according to the listed directions and precautions, from the North Florida Gymnastics and Cheerleading (hereinafter NFGC) Staff. I confirm that I have given at least one dose of the medication without any evidence of side effects or adverse reactions. **I understand that it is my responsibility to provide NFGC with the medication in its original container and labeled with my child's (participant) full name and dosage. I also understand that I must supply NFGC the appropriate measuring device needed to give an accurate dose of the medicine.**

I authorize the NFGC Staff to contact the Pharmacist or Physician for more information about this drug, if necessary. I also authorize the NFGC Staff to contact the Physician regarding my child's (participant) health, if necessary.

_____ _____

Parent/Guardian Signature **Date**

LOG FOR ADMINISTERING MEDICATION

NAME OF MEDICATION	DATE GIVEN	TIME GIVEN	DOSAGE GIVEN	STAFF INITIALS	CHILD INITALS

MEDICATION AUTHORIZATION FORM

Participant Name_____ Male or Female

D.O.B._____/_____/_____ Age_____ Weight_____ Allergies_____

LOG FOR ADMINISTERING MEDICATION

NAME OF MEDICATION	DATE GIVEN	TIME GIVEN	DOSAGE GIVEN	STAFF INITIALS	CHILD INITALS

NORTH FLORIDA GYMNASTICS & CHEERLEADING
11653 CENTRAL PARKWAY, SUITE 212 JACKSONVILLE, FL 32224 PHONE 904.221.5544