CONSENT AND DECLARATION OF PRESCRIPTION MEDICATIONS, OVER-THE-COUNTER DRUGS, AND HEALTH OR MEDICAL MONITORING DEVICES FORM

This form acknowledges a health status of a minor and must be completed for **all** participants participating in a University of South Carolina program for persons under the age of 18.

PARTICIPANT: _____ **DATE OF BIRTH:** _____

Program: _____ **Dates:** _____ - _____

For my child to participate in the described Program, I hereby give consent to receive or give permission for my child to be in possession of the following Prescription Medications, over-the-counter drugs, or health or medical monitoring devices.

Name of Participant's Personal Physician	Telephone number
Address	City State Zip

COMPLETE ONE OF THE FOLLOWING OPTIONS

OPTION A:
No medications/devices are approved: I declare that my child/Participant will not be in possession of any prescription medication, over-the-counter-drugs, nor health or medical monitoring devices, including birth control prescriptions, emergency inhalers (such as for asthma), and emergency injectors for anaphylaxis (such as EpiPen).

Parent/Legal Guardian Initials: _____

OR

OPTION B:
For my child to participate in the described Program, I hereby give consent to receive or give permission for my child to be in possession of the following Prescription Medications, over-the-counter drugs, or health or medical monitoring devices.
Note: A form must be completed for each medication or device. Make additional copies as needed.
Medication: _____

If different from Primary Personal Physician, Prescribing Physician *(name, address and phone #)*

_____

_____

Dosage Instructions: _____

Medical/Health Monitoring Device: _____

Potential side effects: _____

_____

_____

Other information: _____

Parent/Guardian Name _____ Date _____

Signature _____ Emergency Contact Number _____

CHECK-OUT FOR PRESCRIPTION MEDICATIONS, OVER-THE-COUNTER DRUGS, AND HEALTH OR MEDICAL MONITORING DEVICES

NOTE: To be completed by parent/legal guardian on check-in and check-out out day(s).

Log of prescription medications, over-the-counter drug, or health or medical monitoring device transactions with a University representative.

I hereby acknowledge receipt and return of any remaining medications:

Date Released	Signature	Date Received	Signature

OR

I grant permission for my child to be in possession of this prescription medication, over-the-counter drug, or health or medical device:

_____ Date _____

RECEIPT LOG

(Internal document)

Dosage	Date/Time	RC