MEDICATION POLICY

University Program: _____occurring on the following dates: _____

Participant Name: _____ Date of Birth: ____ / ____ / ____
Last *First* *Middle*

OVER THE COUNTER AND PRESCRIPTION MEDICATION

- With the exception of emergency and rescue medication, over the counter and prescription medication is not allowed.
- With limited exceptions, Vanderbilt University does not employ medical professional personnel.
- Programs do not stock over the counter or prescription medications.
- Any undisclosed over the counter or prescription medication found in a Participant's possession will be confiscated. In the event this occurs, program staff will contact Participant's parent/legal guardian. All medication will be returned to the Participant or parent/legal guardian at the end of the day.
- Participant's use of medication for a chronic or long-term medical condition should be well controlled, ideally having been on a consistent course of therapy for three months prior to the beginning of the program.
- Exceptions will be reviewed on a case-by-case basis if failure to take the medication would jeopardize the health of the Participant.

EMERGENCY AND RESCUE MEDICATION

- Participants requiring emergency or rescue medication must be able to self-administer the medication. Program staff members will not administer or assist in the administration of any medications, except in emergency situations.
- Emergency or rescue medication, such as inhalers and EpiPens, are to be kept with the Participant unless otherwise specified by the parent/legal guardian. The self-administration of any prescription medication during the program requires the written authorization of the Participant's parent/legal guardian. All medications must be listed on the Medication Information Form provided.
- All medications must arrive in appropriately labeled and original containers. Medicine in pill boxes or bags is not allowed.
- Medication cannot be shared with others or left unattended.
- It is the responsibility of the Participant to come to the designated staff or location at the correct time or onset of symptoms to obtain their medication (as prescribed), if being stored by this program.
- The designated staff member will log the medication that the Participant took.
- The program is not responsible for missed or incorrect doses. It is not the program staff member's responsibility to follow up with Participants who do not come to self-administer their own medication.

I have read the above medication information and agree to the policies and procedures stated therein.

☐ Participant will not require medication while attending this program.

☐ Participant requires emergency or rescue medication while attending this program. Their medication should be: ☐ Kept with them at all times **OR** ☐ Kept with a designated staff member.

Parent/Legal Guardian's Signature: _____ Date: _____

Parent/Legal Guardian's Printed Name: _____

Faculty Mentor's Signature: _____ Date: _____

MEDICATION INFORMATION FORM

University Program: _____occurring on the following dates: _____

Participant Name: _____ Date of Birth: ____ / ____ / ____
Last *First* *Middle*

PRESCRIPTION EMERGENCY AND RESCUE MEDICATIONS

Medication Name	Dosage & Frequency	Condition/Symptom	Specific Directions	Expected Side Effects
Example: Albuterol Inhaler	*90 mcg / 2 puffs every 4-6 hours as needed*	*Asthma*	*Shake before use*	*Rapid heartbeat, jitteriness and flushing*

Do any of the above medications require special storage, such as refrigeration? ☐ Yes ☐ No
If yes, please explain: _____

Is the Program Participant's condition well controlled? ☐ Yes ☐ No
If no, please explain: _____

Is the Program Participant capable of self-administration? ☐ Yes ☐ No
If no, please explain: _____

PARENT LEGAL/GUARDIAN SIGNATURE AND AFFIRMATION: I hereby affirm that the Participant has been instructed in the proper self-administration and proper use and misuse of the above-described medication or I have explained if the participant is unable to self- administer their medication. I am aware that, unless otherwise stated, this program does not staff medical professional personnel. I understand that a program staff member or other Vanderbilt representative may follow up with the parent/guardian to determine next steps or ask questions if needed.

Parent/Legal Guardian's Signature: _____ Date: _____

Parent/Legal Guardian's Printed Name: _____

Faculty Mentor's Signature: _____ Date: _____

PARENT/LEGAL GUARDIAN MEDICATION AUTHORIZATION AND RELEASE

University Program: _____occurring on the following dates: _____

Participant Name: _____ Date of Birth: ____ / ____ / ____
Last *First* *Middle*

I hereby authorize and recommend the above-named Participant to self-administer all medications outlined in the Medication Authorization Form.

I acknowledge that it may be necessary in certain emergency situations that the participant's rescue medication be administered by an individual on staff other than medical personnel and specifically consent to such practices. I have read and understand the Medication Policy section of this document and acknowledge that Vanderbilt University is not responsible for missed or incorrect doses.

I further acknowledge and agree that Vanderbilt University (Vanderbilt), its trustees, officers, employees, and agents shall not be held liable for any illness or injury resulting from the Participant's possession and/or the administration of medication(s) listed on the Medication Information From while participating in the stated Program activities. I shall indemnify and hold harmless Vanderbilt, its trustees, officers, employees, and agents from and against all claims, damages, causes of action or injuries, including reasonable attorney's fees and costs expended in defense thereof arising out of, incurred, or resulting from the possession and/or administration of medication(s) listed on the Medication Information Form by the Participant.

Parent/Legal Guardian's Signature: _____ Date: _____

Parent/Legal Guardian's Printed Name: _____

Faculty Mentor's Signature: _____ Date: _____