Special Olympics Pennsylvania
Medication Assistance Consent Form

Athlete name: _____

Please state **name(s) of all medication** which the athlete takes, and **dosage** and **times** at which they are normally given. **PLEASE ATTACH COPY OF PRESCRIPTION FOR CONTROLLED SUBSTANCE MEDICATION.**

Everyday medication

Medication name	Dose	Time	Controlled Substance?	Medication taken for:

PRN medication

(Medication as required/needed, for example: paracetamol)

Medication name	Dose	Time	Controlled Substance?	Medication taken for:

What level of assistance does the athlete require to administer medication?

Some Supervision/Assistance ☐ Full Assistance ☐

How does the athlete take their medication? (For example: with a drink, in a yogurt, etc.)

_____

_____

_____

_____

Emergency contact information

Name _____ Phone number _____

Does the medication have storage requirements? (For example: refrigeration, etc.)

_____

_____

_____

_____

List the amount of medication provided to Volunteer Coach (For example: 30 pills, 1 inhaler, etc. – confirm enough medication for entire event)

_____

Any other relevant information?

_____

_____

_____

_____

_____

This form needs to be completed by the parent/guardian/caregiver.

Form completed by: _____

Relationship to athlete: _____

I hereby give permission for an individual nominated by Special Olympics of Pennsylvania to assist _____ **[athlete name]** with taking prescription medication at all training sessions and for the duration of the _____**[year and name [***fall, winter, or spring/summer***] of season]**.

Signature: _____ **Date** _____

Signature of person completing the form