CATHOLIC DIOCESE OF EVANSVILLE
SOURCE + SUMMIT RETREAT
AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY AUTHORIZED PERSONNEL

I HEREBY AUTHORIZE PERSONNEL TO ADMINISTER MEDICATION AS INDICATED TO:

Name: _____Grade _____ Youth Minister _____

Rx Number: _____ Name of Medication: _____

Directions: _____

Doctor: _____Phone: _____Pharmacy: _____Phone:_____
Time(s) medication is given at home: _____
Time(s) medication is to be given at the event: _____

I UNDERSTAND THAT MY SIGNATURE RELIEVES THE PARISH PERSONNEL OF ANY
AND ALL LIABILITY RELATED TO THE ADMINISTRATION OF THE PRESCRIBED
MEDICATION.

Signature of Parent/Guardian X_____Date: _____

Phone number where you may be reached during the event: _____