

DOCTORS RELEASE FOR SELF
ADMINISTRATION OF MEDICATION
SEYMOUR POP WARNER 2010

TEAM: _____

COACH: _____

NAME: _____ **AGE:** _____ **DOB:** _____

MEDICATION (DOSAGES AND HOW OFTEN):

I hereby authorize _____ to self administer above medication,
I have instructed him/her of it's use and he/she is competent to self administer.

DOCTORS SIGNATURE: _____

DATE: _____

PARENTS ACKNOWLEDGEMENT OF ABOVE:

SIGNATURE: _____

DATE: _____

REVIEWED BY MEDICAL DIRECTOR:

SIGNATURE: _____

DATE: _____