# Loudoun County Parks, Recreation, and Community Services

**Long Term Medication Authorization Form** For Prescription and Non-prescription Medications **INSTRUCTIONS:** **Complete a separate form for each medication**

- **Section A** must be completed by the parent/guardian for **ALL** medication authorizations.
- **Section A and Section B** must be completed for any other **long-term medication authorizations** (those lasting longer than 10 working days).
- **PRCS Food Allergy Action Plan**- must be completed by a physician if your child has a diagnosed food allergy. This plan must include steps to be taken in the event of a suspected or confirmed allergic reaction.

**A. To be completed by parent/guardian. Each medication per child requires a separate authorization form**

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| / KÀſŘԿă Name (CⅢăŭ I·yŘ [I·ăŭ) | | Medication Name (as it reads on the label): | |
| Dosage and times to be administered (per instructions on medication): | | Route to administer (orally, intramuscular, inhaler, etc) | |

Condition for which medication is being administered:

If dosage and times to be administered depend on symptoms, please list specific signs and symptoms here:

Special instruction or side effects (if any):

This original authorization is effective from:
_____/_____/_____ until _____/_____/_____ (not to exceed one year)

I hereby authorize the Loudoun County Department of Parks, Recreation and Community Services personnel to give the medication as directed by this authorization. I, on behalf of myself, my executors, administrators, heirs, next of kin, and successors, herby covenant to hold harmless and indemnify the County and all of its officers, departments, agencies, agents and employees from any and all claims, losses, damages, injuries, fines, penalties and costs (including court costs and attorney's fees), charges, liabilities, or exposures, however caused, resulting from, arising out of, or in any way connected to assisting this participant with the use of medication. I have read and understand this HOLD HARMLESS AGREEMENT and by my signature for each medication permission I agree to its terms.

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| Parent Signature: | Date: |

**B. To be completed by child's physician. Each medication per child requires a separate authorization form**

I certify that it is medically necessary for the medication listed above to be administered to (child's yI·YŜύ ψψψψψψψψψψψψψψψψψψψψψ for a duration that exceeds 10 work days.

**PLEASE SELECT WHICH BOX APPLIES:**

☐The above listed child has no known allergies and no Food Allergy Action Plan is needed at this time.

☐The above listed child has a known or suspected food allergy. An attached **Food Allergy Action Plan** has been discussed and reviewed with the parent/guardian.

| | | |
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| Physician Name: | Physician Signature: | Date: |

Revised 7/30/26