

CHILDREN YOUTH AND TEEN PROGRAM
RELEASE OF LIABILITY TO ADMINISTER MEDICATION

(To be completed by Health Care Provider)

Child's Name: _____
Authorized Medication: _____
Reason for Medication: _____
Dosage: _____ Time Administered: _____
Dates Authorized: _____ to _____

I, _____, hereby certify that no reasonable alternative is available to satisfy the
(Health Care Provider's Name)
medical requirement for the aforementioned child. Further, I certify that it is not reasonable nor medically sound to
adjust the medication schedule so that the prescribed medication need not be administered by the Children, Youth
and Teen Program Staff.

(Provider's Signature, Date)

(To be completed by Parent or Guardian)

In consideration of the authorized personnel of Marine Corps Air Station New River, Jacksonville, North Carolina ,
Children, Youth and Teen Program dispensing medication to my child, I, the undersigned, do hereby release the United
States, Department of Defense, Department of the Navy, United States Marine Corps, and their subdivisions, military
and civilian personnel, agents and assigns from any and all liability for any sickness, physical or mental injuries, death
or any and all damages that result to _____, _____, which occurs from said
(Name of Child) (Age)
personnel administering _____.
(Name of Medication)

I understand, and have been instructed by my child's Health Care Provider about the potential side-effects and
negative reactions that could result from the use of the medication named herein. I have provided the personnel for
the Children Youth and Teen Program the following restrictions and instructions in administering the above referenced
medication to my child.
Restrictions:

I understand that by signing this document I am WAIVING MY RIGHT, AND THE RIGHTS THAT MIGHT BE ASSERTED BY
MY CHILD, OUR FAMILY, HEIRS, EXECUTORS, SUCCESSORS, AGENTS, ASSIGNS, AND ALL OTHER RESPONSIBLE PARTIES
ACTING ON OUR BEHALF, TO SEEK RECOVERY FOR INJURIES UNDER THE FEDERAL TORT CLAIMS ACT, OR OTHERWISE
THAT MY CHILD MAY INCUR AS A RESULT OF RECEIVING THIS MEDICATION FROM THE CHILDREN, YOUTH AND TEEN
PROGRAM PERSONNEL, WHO MAY OR MAY NOT BE MEDICALLY LICENSED OR CREDENTIALLED, AND THAT I ASSUME
ALL RISKS OF INJURY ASSOCIATED THEREWITH.

(Printed Name of Parent/Guardian)

(Signature of Parent/Guardian)

DATE

(Printed Name of Witness)

(Signature of Witness)

DATE