



**PRESCRIPTION MEDICINE
DISPENSING AUTHORIZATION**

I hereby certify my child is currently taking medication prescribed by a physician while attending Louisiana Soccer Association ODP Events. I understand the medication may not be kept by my child but will be safely held by the ODP Team Administrator until needed.

Child's Name: _____

Child's ODP Age Group: _____ Child's Gender: M / F (Circle One)

Medications

	Medicine #1	Medicine #2	Medicine #3
Name:	_____	_____	_____
Date Prescribed:	_____	_____	_____
Doctor:	_____	_____	_____
Doctor's Phone:	_____	_____	_____
Dosage:	_____	_____	_____
Hours to be Taken:	_____	_____	_____
Other Instructions:	_____		

Remarks: _____

Parent or Guardian's Name: _____

Relationship to Child: _____ Mother; _____ Father; _____ Other: _____

Phone where you can be reached during the day: 1. _____ 2. _____

I hereby give my permission for the above medication to be administered to my child by a Louisiana Soccer Association ODP Administrator in accordance with the instructions given.

Signature: _____ Date: _____

Member: US Soccer Federation - US Youth Soccer - US Adult Soccer Association.