



**REQUEST TO ADMINISTER MEDICATION -
LIFE-THREATENING ALLERGY
Epi-Pen Permission Form**

TO BE COMPLETED BY THE PARENT/GUARDIAN AND PHYSICIAN

FOR COMPLETION BY PARENT/GUARDIAN

Last Name _____ First Name _____ Date of Birth / /

Address _____ Phone Number ()

City _____ State _____ Zip _____

Allergies

I hereby grant Junior RAMS Cheerleading coaches, volunteers, etc. (“Agents”), permission to administer the prescribed medication as directed by the undersigned licensed health care provider and certify that the athlete will carry it on their person during all Junior RAMS practices, competitions, events, activities, etc.

Parent Signature _____ Date _____

My child _____ has been instructed by _____ in the proper administration of _____. It is my belief that _____ is capable of using this medication appropriately and independently. I am requesting that _____ be permitted to carry _____ and self-administer as needed. I have instructed _____ to inform a Junior RAMS Cheerleading coach if this medication has been self-administered during a Junior RAMS Cheerleading activity or event.

Parent Signature _____ Date _____

I furthermore agree to the indemnification agreement contained below:

The parent or guardian agrees to indemnify, defend, and hold harmless for any and all claims, actions, costs, expenses, damages and liabilities, including attorney fees, arising out of, connected with, or resulting from the administration of medication by a Junior RAMS Agent or from the self-administration of medication by the participant.

The parent or guardian agrees the RHS Cheerleading Booster Club, Inc.- Junior RAMS Division and its Agents shall incur no liability as a result of any injury arising out of or connected with the administration of medication by a Junior RAMS Agent or from the self-administration by the participant.

This agreement shall take effect on the date listed below and shall stay in effect for as long as the participant is provided permission to use medication or self-administer medication. This agreement must be renewed for each subsequent sports season. This agreement must be signed and in full effect prior to the granting of permission to administer or self-administer medication.

Parent Signature _____ Date _____

FOR COMPLETION BY PHYSICIAN

I certify that this child has an allergy to _____ Please administer _____ for the symptom of _____

I have certified that this child may self-administer the above medication. Yes No

Physician Signature _____ Date _____

Physician’s Stamp