STEM-U MEDICATION AUTHORIZATION & SUPPORT PLAN

One medication per form

IMPORTANT

This form establishes the approved written medication plan for a STEM-U participant. It does not authorize STEM-U personnel to diagnose, alter medication, calculate or change a dosage, make independent medical decisions, or provide medication outside the written plan. STEM-U must approve any staff-supported arrangement before departure.

1. PARTICIPANT & PROGRAM INFORMATION

Participant full legal name		**Date of birth**	
STEM-U program / destination		**Travel dates**	
Parent / legal guardian		**Best phone during travel**	
Prescribing provider		**Provider phone**	

Emergency contact information maintained in the STEM-U registration portal will be used for emergency communications.

2. MEDICATION INFORMATION

Medication name	
Purpose / condition treated	
Dose and route	
Scheduled time(s) and frequency	
Start / stop date, if applicable	
Storage requirements, including refrigeration	
Known side effects, precautions, or special instructions	

Required packaging: Prescription medication must be supplied in the original pharmacy-labeled container. The participant name, medication, dosage, and instructions must match this approved plan. Do not combine medications in one container.

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3. SELECT THE MEDICATION SUPPORT PLAN

☐ A. INDEPENDENT SELF-ADMINISTRATION

The participant is capable of carrying and self-administering the medication correctly without reminders or assistance.
☐ Participant may carry this medication personally. ☐ Medication will be stored securely and accessed independently under the approved plan.

☐ B. SUPPORTED SELF-ADMINISTRATION

The participant is capable of taking the medication correctly but requires routine adult support. Support may include secure storage, a scheduled reminder, making the properly labeled medication available, observing self-administration when appropriate, returning it to storage, and documenting the support provided.
Support requested: ☐ Secure storage ☐ Scheduled reminder ☐ Medication made available ☐ Observation ☐ Documentation

☐ C. INDIVIDUAL MEDICATION PLAN REQUIRED

The participant cannot independently self-administer, the medication requires clinical judgment or specialized administration, or the requested support exceeds routine assistance. STEM-U must review the need before the participant travels. Participation or the medication plan may require additional provider instructions, a trained support person, or another approved arrangement.
☐ Parent/guardian requests an individual review before departure.

4. EMERGENCY OR RESCUE MEDICATION

Complete this section for epinephrine auto-injectors, rescue inhalers, glucagon, seizure rescue medication, or other emergency medication. Attach the current provider-directed Emergency Action Plan.

Emergency medication	
Condition, symptoms, or triggers	
When the medication should be used	
Participant carries medication	☐ Yes ☐ No
Backup medication location	
Emergency Action Plan attached	☐ Yes ☐ No
After use / emergency instructions	Call local emergency services as directed in the Emergency Action Plan and notify the parent/guardian and STEM-U emergency contact.

Emergency-response limitation: The actions STEM-U personnel may take with emergency medication depend on the participant's written plan, provider instructions, applicable law, staff training, and STEM-U approval. Calling emergency services and following the participant's Emergency Action Plan remain central to the response.

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5. PARENT / LEGAL GUARDIAN AUTHORIZATION

- I confirm that the information on this form is complete and accurate and matches the medication label and current provider instructions.
- I authorize the medication plan selected above and understand that STEM-U must approve any staff-supported or individual arrangement before departure.
- I understand that the participant must not share medication, alter the dosage or schedule, or carry medication contrary to the approved plan.
- I will promptly provide updated written instructions and replacement medication if the prescription, dosage, schedule, packaging, expiration date, or participant's needs change.
- I authorize STEM-U to share medication information on a need-to-know basis with designated personnel, emergency responders, medical providers, and travel partners when reasonably necessary for participant safety.

- I understand that verbal instructions, text messages, informal conversations, or unapproved medication changes do not replace the required written documentation.

Parent / guardian printed name		**Relationship**	
Signature		**Date**	
Best phone during travel		**Email**	

6. HEALTHCARE-PROVIDER AUTHORIZATION — WHEN REQUIRED

STEM-U may require provider authorization for prescription medication, emergency or rescue medication, medication requiring secure storage or staff-supported assistance, a specialized medication need, or any plan requiring additional medical clarification.

Provider name		**License / credentials**	
Practice / facility		**Phone**	
I confirm the medication, dose, route, schedule, and instructions above are current.			
Provider signature		**Date**	
Additional instructions attached		**☐ Yes ☐ No**	

7. STEM-U REVIEW & APPROVAL

Plan approved	☐ Independent self-administration ☐ Supported self-administration ☐ Individual plan attached ☐ Not approved
Approved support details	
Storage location / access plan	
Designated personnel / documentation method	
Reviewer signature and date	

Submit this completed form and all required attachments by the deadline provided for the program.