

Policy for Use of Medication During a HOBY Event

If a minor or adult participant is required to take medication during a HOBY event, including the HOBY Leadership Seminar, he/she must comply with the following guidelines:

1. HOBY volunteers will not dispense prescription medication for participants during the event.
2. Any participant bringing prescription medication to the event must submit a doctor's note or completed Physician Medication Verification Form to HOBY, preferably in advance or at the event check-in, detailing the following:
 - a. The name and type of medication.
 - b. The condition for which the medication is being prescribed.
 - c. Dosage information.
 - d. Attestation that use of the medication will not impair the participant's ability to care for his/her own safety or the safety of others; increase the risk of harm to others; or cause dizziness and/or fatigue.

This information is necessary to provide medical personnel in the case of emergency and the participant is unable to communicate the information. All prescription medication must be submitted to HOBY in its original container as labeled by the pharmacy. HOBY will store required medications in a locked facility. The medications a participant may be allowed to keep in his/her possession is any asthma medications (inhalers, oral steroids, etc.), birth control pills, acne medication, any topical medications, allergy medications, medications for treatment of diabetes (insulin, etc.) and EpiPens, as well as any other prescription medication required by the doctor to be in their possession at all times. But there will need to be a doctor's note completed and on file for all medication brought to the event, whether stored or not.

If a participant fails to advise HOBY that he/she is taking prescription medication, is not taking the medication as prescribed, and/or has stopped taking prescription medication, HOBY reserves the right to send the participant home at the participant's guardian or parent's expense.

3. If the participant has a medical condition that requires any assistance, the assistance must be provided or contracted directly by the participant or his/her parent/guardian. Under no circumstances will a HOBY volunteer help with dispensing medication. If help is needed on an emergency basis, emergency personnel will be contacted.
4. Proper administration and dosage of medication shall be the sole responsibility of the participant. HOBY will have no responsibility in seeing that the participant takes the medication as prescribed by the doctor.
5. Participants should only bring as much medication as will reasonably be needed during the event.
6. Participants are prohibited from sharing their personal medication with another participant. Conversely, participants are prohibited from accepting medication from anyone, other than HOBY medical staff.
7. Any participant bringing illegal drugs, narcotics, misused prescription drugs and/or mood-altering substances or alcoholic beverages to a HOBY event, using them on HOBY premises or dispensing or selling them on HOBY premises will be subject to disciplinary action, including automatic expulsion from the event. The discharged participant will be responsible for any charges/fees incurred as a result of leaving the event early (i.e. change in airfare, taxi, etc.). HOBY has a very strict/no-tolerance policy when it comes to drugs.



Only bring this form to check-in if will be using medication onsite at HOBY
(per the attached medication use policy)

Medication Verification Form for Physicians

(Please type or print legibly)

(This form is to be completed by the participant's prescribing physician. If the participant has more than one prescribing physician, then each physician will need to complete a form. Please type or print legibly.)

1. Name of Participant/Patient: _____
2. Prescribing Physician Name: _____
3. Prescribing Physician Medical License Number and State where licensed: _____
4. Please complete the chart below for the medications which you have prescribed to the participant.

Name of Medication	Type of Medication	Condition for Treatment	Dosage	Frequency

5. Please affix physician's business card or voided prescription in the space below.

As the prescribing physician, I attest that the use of the medications prescribed by me, and taken as directed as listed above, should not impair the participant's ability to care for his/her own safety or the safety of others; increase the risk of harm to others; or cause dizziness and/or fatigue.

Signature of Prescribing Physician: _____

Date: _____