ADVENTURE CLUB MEDICATION ADMINISTRATION FORM

Parent Authorization to Administer Medication in Adventure Club

The parent/guardian of (child's name) ________________________________ DOB: _________ Grade: ____ requests that Adventure Club Staff administer the below described medication(s) to my child according to the Health Care Provider's/Licensed Prescriber's signed instructions below.

It is parent/guardian's responsibility to furnish the necessary medication and administer the first dose. The parent/guardian agrees to give the child's Health Care Provider/Licensed Prescriber permission to share information about the administration of this medication with Adventure Club Staff delegated to administer medication, if necessary.

Prescription Medications must be packaged in its original container with the prescription label properly affixed thereto and listing: child's name, name of medicine, time medicine is to be given, dosage, date medicine is to be stopped, licensed health care provider's name, and pharmacy name and phone number. Dosage must match the signed Health Care Provider/Licensed Prescriber authorization below. Inhalers and epinephrine injectors do not require the section below to be completed by a health care provider/licensed prescriber.

Over-the-Counter Medications must be packaged in original container and be labeled with child's name. Dosage must match the signed health care provider authorization below. Sunscreen may be applied without signature of health care provider/licensed prescriber.

By signing this document, I give permission for Adventure Club Staff to administer the medications as listed below in accordance with Adventure Club policies.

___________________________________ ___________________________________ ___________

Parent/Guardian Name Parent/Guardian Signature Date

Health Care Provider/Licensed Prescriber Authorization to Administer Medication in Adventure Club

Not required for inhalers and epinephrine injectors

Please attach additional sheets if necessary

Attention Health Care Provider/Licensed Prescriber: Adventure Club is a before and after school program that is not staffed with a school nurse or medically-trained professionals. As such, medication would be administered by school-aged care staff and not by, or under the supervision of, a school nurse or medically-trained professional.

Medication: ____

Dosage: ______________________________ Route: ____

To be given at the following time(s): ____

Special instructions: ____

Purpose of medication: ____

Potential side effects of medication: ____

Starting Date: _________________________ Ending Date: _________________________

By signing below, you acknowledge that school-aged care staff would be administering the below listed medication(s) to the child identified above.

___________________________________ ___________________________________

Health Care Provider/Licensed Prescriber Name Health Care Provider/Licensed Prescriber Signature

___________________________________ _________________________

Phone Number Date

Adventure Club Administrator Approval

Adventure Club agrees to administer medication as prescribed above by the Health Care Provider/Licensed Prescriber.

________________________________ ____________________________

Adventure Club Administrator Signature Date