

AUTHORIZATION FOR DRUG/MEDICATION ADMINISTRATION BOYS AND GIRLS CLUBS OF KAWARTHA LAKES

This form must be completed by the parent of a child who is requesting that a drug of medication be administered during hours that the child receives child care, in accordance with the Boys & Girls Clubs of Kawartha Lakes medication administration policy and procedures

Child's Full Name:							
Child's Date of Birth	(dd/mm/yyyy):						
Date Authorization Form Completed (dd/mm/yyyy):							
Date Authorization Form Updated(dd/mm/yyyy):							
Name of Drug or Me (as per the original							
Date of Purchase or (dd/mm/yyyy)	Date Dispensed:						
Expiry Date: (dd/mn	n/yyyy)						
Authorization Start	Date (dd/mm/yyyy)						
Authorization End [Date (dd/mm/yyyy)						
Method of Medication Administration (initial below)							
Boys & Girls Clu	Boys & Girls Clubs of Kawartha Lakes staff are to administer the drug/medication to my child						
My Child will self-administer the drug or medication (Optional for children who attend school only)							
Authorization for Child to Carry Emergency Asthma Medication							
I authorize my child to carry their own asthma medication.							
Not applicable (this authorization is not for asthma medication).							
Medication Administration Schedule							
The drug or medication needs to be administered according to the following schedule:							
Day(s) of the week	Time(s) of the Day/Intervals	Amount/Dosage	Additional Information (where applicable)				

- This form is required for over the counter and prescription medications
- o A separate form is required for each drug or medication that a child requires



AND/OR, where drugs are to be administered on an "as needed" basis:

The	drua d	or medication	needs to be	administered	when the	following	phy	vsical s	vmpto	ms are	observed	:

Symptoms:	
Amount/Dosage:	
Parent/Guardian Authorization	Statement:
Girls Clubs of Kawartha Lakes to	er, Coordinator of the department or a designated staff, of the Boys and administer the above-named drug or medication to my child and handle the procedures I have provided on this form.
	medications will not be administered to my child at any time in accordance wartha Lakes medication administration policy.
I understand that staff at Boys ar drugs and medications.	nd Girls Clubs of Kawartha Lakes are not medically trained to administer
Print Name:	Relationship to child:
Signature:	Date Signed:(dd/mm/yyyy)
Received By:	
Print Name:	Position:
Signature:	Date Signed:(dd/mm/yyyy)