REQUEST FORM FOR ADMINISTRATION OF PRESCRIPTION MEDICATION DURING KIDS CLUB / HIVE TIME
Parents or Guardians of children requesting that medication be administered during Kids Club/Hive Time hours by Site Supervisor or trained individuals are required to provide for Kids Club/Hive Time: 1) Physician's order for administration or 2) a parental request for the administration of medication.

Parent/Guardian complete the following information per MN DHS policies

Child's Name:_____Grade:_____Birthdate:_____
Childcare Site:_____
Parent/Guardian Name:_____
Home Address:_____
Description of Health/Medical Concern or Allergy:
_____
_____
Is this health/medical condition or allergy life threatening? Yes or No
What triggers (if any) are associated with your child's health/medical concern or allergy?_____
_____
Best techniques to avoid an allergy reaction:_____
Symptoms of an allergic reaction specific to your child:_____
Procedure for how to respond to allergic reaction or health/medical concern:
_____
_____

Physician's order for administration of medication by Kids Club / Hive Time

I have prescribed the following medication for this child and request the dosage given during Kids Club/ Hive Time hours be administered by the Site Supervisor or trained individual.

Diagnosis:_____ Medication:_____
Dosage and time:_____
Physician's Name (print):_____
Physician's Signature:_____
Physician's Address:_____ Phone:_____

Parental request for administration of medication

I request this medication be given as prescribed. I release Kids Club/Hive Time personnel from any liability in relation to the administration of this medication at Kids Club/Hive Time. I authorize the exchange of information regarding these medications between the clinic and the Kids Club/Hive Time for the duration of the year. Medication provided to the site should be provided in the original container, labeled with your child's first and last name, and not expired.

Parent/Guardian Signature:_____Date:_____
Diagnosis:_____Name of Medication:_____
Administering Instructions:_____
Dosage and time:_____
Physician's Name (print):_____
Physician's Address:_____ Phone:_____

<u>For Staff Use Only:</u>

ALWAYS review the written Parent/Guardian medication instructions and/or Health Care Provider's medical order prior to EVERY administration.
7 Rights MUST be performed with EVERY dose! Right **child**, right **medication**, right **dose**, right **route**, right **time**, right **reason**, right **documentation**.

Date Given	Time Given	Dose Given	Route Given	Comments/reactions	Staff Full Signature	Printed Staff Full Name
