



REQUEST FORM FOR ADMINISTRATION OF NON-PRESCRIPTION MEDICATION

Parents or Guardians of children requesting that non-prescription medication be administered during Kids Club/Hive Time hours by Site Supervisor or trained individual are required to provide for Kids Club/Hive Time: 1) Physician's order for administration if non-prescription medication usage is to exceed two weeks or 2) a parental request for the administration of non-prescription 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 non-prescription medication by Kids Club / Hive Time (if non-rx usage is to exceed two weeks)

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: _____ Name of Medication: _____

Dosage and time: _____

Physician's Name (print): _____

Physician's Signature: _____

Physician's Address: _____ Phone: _____

Parental request for administration of non-prescription medication by Kids Club / Hive Time

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: _____

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