AUTHORIZATION TO ADMINISTER MEDICATION / OVER THE COUNTER PRODUCTS

(For example: Prescriptions, OTC medications, Sunscreen, bug spray, lip balm, lotion etc.)

Complete entire form. Print clearly, using ink, not pencil.

Today's Date: _____

Child's name: _____Date of Birth:_____

Please administer medication as specified below:

Name of medication: _____

Date medication begins: _____Date medication ends: _____

Does medication need to be stored in the refrigerator? Yes No

Instructions for use of medication:

Dosage/amount: _____How administered: _____

When is medication to be given? (Circle and specify):

At set times of day (specify time and AM/PM) _____

When symptoms occur (such as pain, asthma, etc. - describe clearly):

_____

In an emergency (such as allergic reaction, anaphylaxis – describe clearly):

_____

Special instructions (such as with/without food; foods to avoid, etc.)

_____

Possible side effects (such as drowsiness):

_____

I hereby authorize a trained Cambridge-Isanti School official to assist my child in the administration of the medications that I have listed above in non-emergency situations. During an emergency, I authorize any and all physicians, trained school personnel, and/or other medical providers to render such emergency treatment and to release the above health information as deemed necessary for the health of my child. If any emergency medical procedures or treatments are required, I consent for the supervisor to arrange for them at the supervisor's discretion. If nursing assistance is needed for a medical treatment or procedure, I consent for the supervisor to arrange for them at their discretion. Short term need medications must be picked up by a parent at the end of the week. It will not be given to a child/sibling to take home.

Parent/guardian signature: _____Date:_____

MEDICATION ADMINISTERED AT ADVENTURE CENTER

Daily Medication Form

Administration records not required for sunscreen, bug spray, lip balm, or lotion

Complete entire section. Print clearly, using ink, not pencil.

Name of medication: _____

Time medication last given at home: _____

Given by: _____

Time(s) medication given at child care program: Given by: (print name and signature)

_____AM PM Name (print): _____

Signature: _____Dosage:_____Date:_____

Time(s) medication given at child care program: Given by: (print name and signature)

_____AM PM Name (print): _____

Signature: _____Dosage:_____Date:_____

Time(s) medication given at child care program: Given by: (print name and signature)

_____AM PM Name (print): _____

Signature: _____Dosage:_____Date:_____

Time(s) medication given at child care program: Given by: (print name and signature)

_____AM PM Name (print): _____

Signature: _____Dosage:_____Date:_____

Time(s) medication given at child care program: Given by: (print name and signature)

_____AM PM Name (print): _____

Signature: _____Dosage:_____Date:_____

Comments:

_____

_____