Kirkwood Adventure Club
Medical Administration Authorization

School: ❒ North Glendale ❒ Keysor ❒ Tillman ❒ Robinson ❒ Westchester

Child's Name: ____

Physician: ___________________________ Diagnosis: _____________________________

Name of Medication: ____

Dosage: ____________________________ Time of Last Dose: _______________________

Time medication need to be administered: ________________ AM/PM

How Long Medication to be administered: ____

I understand that:

- **Medication must be in the original container**
- **If a prescription drug, must be labeled by a pharmacist with name, dose, amount of medication and physician's name.**
- **If a non-prescription drug, must be accompanied by a physician authorization giving the name of the child, the name of the medication, does an frequency of dose.**
- **I will notify the Adventure Club Coordinator and Program Assistant in writing of any change in dose or time.**
- **The school may NOT give the first dose of any medication.**

As the parent or guardian of my child, I hereby request that he/she receive the above medication while at **Adventure Club**.

Parent/ Guardian Signature: ________________________________ Date: _______________

*****For Office Only*****

Medication Received By: _________________________ Date: __________________________