

REQUEST FOR ADMINISTRATION OF MEDICATION FOR BRONCO CLUB

Parent/Guardian: This section must always be completed by the parent or guardian.

Type of Medication (check all that apply):

- Prescription Medication
- Nonprescription Medication
- Topical Product or Lotion
- Refrigeration Required
- Food Supplement
- Modified Diet

Child Information

Name of Child: _____

Date of Birth: _____

Weight: _____

Medication Details

Name of Medication: _____

Exact Dose: _____

Administration Times: _____

Duration of Administration: _____

I understand that my child must receive one dose of medication before arriving at the program (unless medication is used for emergencies).

Parent/Guardian Signature: _____

Date: _____

Provider: This section must always be completed by a licensed physician, dentist, or certified physician assistant.

1. The medication contains codeine or aspirin.
2. A physician's instruction is needed for a nonprescription medication (e.g. child does not meet minimum age or weight requirements as listed on the label instructions).
3. It is a sample medication without a prescription label.
4. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period.
5. The topical product or lotion and the physician's instructions exceed the manufacturer's instructions or use.

Child Information

Name of Child: _____

Name of Medication: _____

Exact Dose: _____

Side Effects to Watch For: _____

Expiration Date (May not exceed twelve months from the date of this request for medications or food supplements).

Expiration Date: _____

Special Instructions: _____

This child is under my care and should receive the above medication as written.

Signature of physician, dentist, or certified physician's assistant: _____

Date of Signature: _____

Phone Number: _____

