

## Kids Club Medication Consent Form

CHILD'S NAME: \_\_\_\_\_

CHILD'S CONDITION FOR ADMINISTRATING MEDICATION (please check one):

Cold                       Ear Infection                       Injury  
 Rash                       Sore Throat                       Other: \_\_\_\_\_

NAME OF MEDICATION: \_\_\_\_\_

Prescription     Non-prescriptions     Doctor's approval required

NAME OF DOCTOR WHO PRESCRIBED: \_\_\_\_\_

AMOUNT TO BE ADMINISTERED: \_\_\_\_\_

TIME (S) MEDICATION TO BE ADMINISTERED: \_\_\_\_\_

DATES MEDICATION TO BE ADMINISTERED: \_\_\_\_\_

REFRIGERATION NECESSARY:     YES                       NO

POSSIBLE ADVERSE REACTIONS: \_\_\_\_\_

*I authorize the administration of medication to my child.*

PARENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Dates Administration	Time (s) Administration	Adverse Reactions Observed	Staff Member's Initials

- Is all of the above information complete?
- Is medicine in the original container with the prescription label on it?
- Is the child's name on the container?
- Is the date of the prescription current?
- Is the name of the drug, dose, and administration schedule given on the label the same as the instructions given by the parent?
- Has the medication been placed out of reach of the child?
- This form is only good for two weeks and must then be resigned by the parent.