Medication Administration Request: School Year 2019-2020

Medications may only be administered at 5:00pm or 6:00pm

Child/ Client: _____ Birth date: _____

Medication: _____
(One medication per form)

Dosage: _____
(Please cut pills if needed prior to dropping off medication)

Time of Day (circle): As Needed 5:00pm 6:00pm

How to administer: _____

Condition Prescribed for: _____

Possible side effects: _____

All medication must be in original container and administered per prescription label directions

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I authorize the above medication(s) to be administered to my child at the TrueNorth Wellness Services Amazing Kids Club by staff persons or volunteers who are not physicians, licensed registered nurses (RNs), or licensed practical nurses (LPNs). I understand, acknowledge and approve that the individuals administering the medication do not have any form of medical license and will not perform a medical assessment of my child prior to administering the authorized medication.

TrueNorth Wellness Services Amazing Kids Club bears no responsibility for ensuring that the medication is taken. I do hereby release, discharge and hold harmless the TrueNorth Wellness Services Amazing Kids Club, its agents and employees, from any and all liability and claim whatsoever for the administration of the above medication to this child/ client, should reaction develop from this medication.

_____ _____
Parent/ Guardian Signature Date

OFFICE USE ONLY

___ APPROVED _____
Administrative Coordinator Signature

___ Scanned (R) ___ Filed in Master Binder (SS) ___ Filed with Med.(SS) ___ Filed in Safety Bag (SS)