AUTHORIZATION TO ADMINISTER MEDICATION

In order for children who need to take over the counter or prescription medications during BHCCB programs, this form needs to be completed in entirety by a parent/guardian *and* physician before any medication can be given my staff members, ***even over the counter medications.*** If the form is incomplete or not on file, the parent will need to return to the BHCCB program to administer the medication regardless of the age of the child.

Parents please complete this section

The parent or guardian of_____ask that the BHCCB staff give the following medication_____at_____to my child, according to the health care providers signed instructions on the lower part of this form.

Prescription medications must come in the original container with the child's name, name of the medicine, time the medicine is to be given, dosage, and date the medicine is to be stopped and a licensed health care provider's name. Pharmacy name and phone number must also be included on the label. Ask your pharmacist for a separate medicine bottle to be kept at program location. **Over the counter medications** must be labeled with the child's name. Dosage must match the signed health care provider authorization and medicine must be packaged in the original container.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with BHCCB staff.

_____ _____ _____

Parent/Guardian printed name Parent/Guardian Signature Date

_____ _____

Cell phone Work phone

Health Care Provider Authorization to Administer Medication at BHCCB Program

Child's Name_____ Date of Birth_____

Medication_____Dosage_____

To be given at the following time(s) (be specific, we cannot use "as needed") _____

_____

Special Instructions_____

Purpose of the Medication_____

Side effects that need to be reported_____

Physician/Health Care Professional Signature:_____

It is understood that the medicine is administered at the request of and as an accommodation to the undersigned parents or guardians. In consideration of this acceptance of the request to perform the service by BHCCB personnel, the undersigned hereby agrees to release the BHCCB from legal claims which they now have or may hereafter have arising out of the administration or failure to administer the medication to the participant .

Parent/Guardian Signature: _____*Date*_____