

AUTHORIZATION FOR DRUG/MEDICATION ADMINISTRATION

BGC South East

This form must be completed by the parent of a child who is requesting that a drug or medication be administered during hours that the child receives child care, in accordance with the child care centre's medication administration policy and procedures.

Child's Full Name: _____

Child's Date of Birth (dd/mm/yyyy): _____

Date Authorization Form Completed (dd/mm/yyyy): _____

Date Authorization Form Updated (dd/mm/yyyy): _____

Name of Drug or Medication (as per the original container label):	
Date of Purchase or Date Dispensed: (dd/mm/yyyy)	
Expiry Date: (dd/mm/yyyy)	
Authorization Start Date: (dd/mm/yyyy)	
Authorization End Date: (dd/mm/yyyy or ongoing)	

Method of Medication Administration

Child care centre staff are to administer the drug or medication to my child. ____ **(initial)**

Authorization for Child to Carry Emergency Allergy Medication *(choose 1)*

- I authorize my child to carry their own asthma medication.
- Not applicable (this authorization is not for asthma medication).

Medication Administration Schedule

The drug or medication needs to be administered according to the following schedule:

Day(s) of the Week	Time(s) of the Day / Intervals	Amount/Dosage	Additional Information (where applicable)

AND/OR, where drugs are to be administered on an 'as needed' basis:

The drug or medication needs to be administered when the following physical symptoms are observed:

Amount/Dosage:

Parent/Guardian Authorization Statement:

I hereby authorize the person in charge of drugs or medications at Boys & Girls Club to administer the above-named drug or medication to my child and handle the drug or medication in accordance with the procedures I have provided on this form.

I understand that expired drugs or medications will not be administered to my child at any time in accordance with the child care centre's medication administration policy.

I understand that staff at Boys & Girls Club are not medically trained to administer drugs and medications.

Print name: _____	Relationship to Child:
Signature: _____	Date Signed: (dd/mm/yyyy)

Received By:

Print name: _____	Role at Child Care Centre:
Signature: _____	Date Signed: (dd/mm/yyyy)

For Office Use Only

Location medication will be stored:

Date Drugs/Medication Returned to Parent / Pharmacy (dd/mm/yyyy):

Special Instructions:

- This form is required for over-the-counter and prescription medications. For non-prescription skin products, the Authorization to Administer Non-Prescription Skin Products form must be completed.
- A separate form should be completed for each drug or medication that a child requires.
- Children's personal health information should be kept confidential.