



**BOYS & GIRLS CLUBS
OF BELLEVUE**

Medication Authorization Form

Site: _____ Date: _____

The Parent/Guardian of the member must complete this section: (please print)

Members Name: _____	Birthdate: _____
Medication(s): _____	
Health Care Provider: _____	Phone/Fax: _____
<u>Please initial & sign below:</u>	
_____ I request that the authorized persons at the Club assist my child in taking the medicine(s) described below.	
I understand that:	
<ul style="list-style-type: none"> • I will keep track of expiration dates for the medication(s) • My signature gives permission for exchange of information between the Club staff and the Health Care Provider regarding this medication order. • I will furnish medication(s) in original container and pick up medication(s) from the Club. 	
_____	Date: _____ Phone: _____
Parent / Guardian Signature	

This section is to be completed by the Health Care Provider (please print): (MD, DO, DMD, DC, PA, ARNP or CMN)

Medication name:		
Dose:		
Route, circle one:	Oral/inhaler/Eye Drops/ Ear Drops/ Other	Oral/inhaler/Eye Drops/ Ear Drops/ Other
Reason/Diagnosis (if epinephrine, please state specific allergens):		
Time of dose:		
Side Effects:		
When to repeat:		
Authorization for:	<input type="radio"/> School Year <input type="radio"/> Summer <input type="radio"/> Other Dates:	<input type="radio"/> School Year <input type="radio"/> Summer <input type="radio"/> Other Dates:

I request that the above named member be administered the above medication in accordance with the instructions indicated, as there exists a valid health reason which makes administration advisable during Club hours.

Licensed Health Care Provider's Signature:	Date:	Phone: Fax:
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