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:_______________________

Please initial & sign below:

_____ I request that the authorized persons at the Club assist my child in taking the medicine(s) described below.

I understand that:

- 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:	○ School Year ○ Summer ○ Other Dates:	○ School Year ○ Summer ○ 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:**