



## Stateline Boys & Girls Club: Bruce Nichols Campus

## Medication Consent Form

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Child Care Center Name:					
		Time(s) of day to be	How to be	Dates- Medicat	Dates- Medication Time Period
Name of Medication	Dosage	administered	administered	From	То
		☐ AM ☐ PM			
		☐ AM ☐ PM			
		☐ AM ☐ PM			
		AM PM			
es No <b>Does the ove</b> s physician and I am auth	er-the counter- orizing a dosage	OTC) medication label inc consistent with the physi	licate the child's physic	an should be consulte	hould be consulted? If "Yes" O have consulted with my
Yes No Does the over-the counter- (OTC) medication label indicate the child's physician sl child's physician and I am authorizing a dosage consistent with the physicians recommendation.  OTC Medication Name Parent Initials	er-the counter- (	OTC) medication label inc	dicate the child's physiciicians recommendation.  Parent Initials	an should be consulte	d? If "Yes" O have
es No Does the overs physician and I am auth Medication Name	er-the counter- (	Yes No Does the over-the counter- (OTC) medication label indicid's physician and I am authorizing a dosage consistent with the physician TC Medication Name	dicate the child's physic cians recommendation Parent Initial fy.	ian should be consulte	d? If "Yes" O have
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es No Does the oves physician and I am auth	orizing a dosage	Yes No Does the over-the counter- (OTC) medication label indicate the child's physician should be consulted's physician and I am authorizing a dosage consistent with the physicians recommendation.  C Medication Name Parent Initials Parent Initials Individual Information/ Special instructions/contraindication-Specify.	dicate the child's physic cians recommendation.  Parent Initial  fy.  Id by staff of the child company to the chil	ian should be consulte	d? If "Yes" O have

## **Documentation of Medication Administration**

Instructions: This section is to be completed only by Stateline Boys & Girls Club employees to document the actual administration of the medication.

Lines should not be skipped

28.	27.	26.	25.	24.	23.	22.	21.	20.	19.	18.	17.	16.	15.	14.	13.	12.	11.	10.	9.	.∞	7.	6.	5.	4.	ω.	2.	1.	
																												Name of Medication
																												Date Administered
																												Time Administered
																												Dosage
																												Signature/initial of person who is administering the medication