



STATALINE
BOYS & GIRLS CLUBS



United Way
Blackhawk Region
Funded Partner

Stataline Boys & Girls Club: Joel Barrett Campus

Medication Consent Form

Name of child: _____ Birth Date: _____

Child Care Center Name: _____

Name of Medication	Dosage	Time(s) of day to be administered	How to be administered	Dates- Medication Time Period	
				From	To
		<input type="checkbox"/> AM <input type="checkbox"/> PM			
		<input type="checkbox"/> AM <input type="checkbox"/> PM			
		<input type="checkbox"/> AM <input type="checkbox"/> PM			
		<input type="checkbox"/> AM <input type="checkbox"/> PM			

Yes No **Does the over-the counter- (OTC) medication label indicate the child's physician should be consulted?** If "Yes" O have consulted with my child's physician and I am authorizing a dosage consistent with the physicians recommendation.

OTC Medication Name _____ Parent Initials _____

Additional Information/ Special instructions/contraindication- Specify.

I hereby authorize administration of the above medication to my child by staff of the child care center listed above

Signature- Parent or Guardian

Date

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

	Name of Medication	Date Administered	Time Administered	Dosage	Signature/initial of person who is administering the medication
1.					
2.					
3.					
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