AUTHORIZATION FOR DRUG/MEDICATION ADMINISTRATION

Name of program:_____

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 is attending the program, in accordance with the Town of Minto'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 (Initial Below)

☐ Town of Minto Staff are to administer the drug or medication to my child. _____

☐ My child will self-administer the drug or medication. _____

Authorization for Child to Carry Emergency Allergy Medication

☐ I authorize my child to carry their own asthma medication.

☐ Not applicable (this authorization is not for asthma medication).

Medication Administration Schedule

☐ This 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 the _____ *(name of program)* 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 Town of Minto's medication administration policy.

I understand that staffs at the _____ *(name of program)* 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 the _____ *(name of program)*:**
Signature:	**Date Signed (dd/mm/yyyy):**