MEDICATION INFORMATION AND TREATMENT AUTHORIZATION

Seattle Parks & Recreation

ARC

It is important that we are aware of any medication your child may be taking in case of emergency. Please complete **BOTH** sides of this form and provide information regarding medication your child takes whether or not it will be taken during child care hours. All medication taken during child care hours must be administered by staff.

Child's Name ______________________________ Date of Birth ______________ Age _____
(last) (first)

Medication Administration

State law prevents our personnel from administering medication unless we have a signed note from a physician stating dosage and procedure. If medication is required to be administered during child care hours, please bring this form and the medication in its prescription bottle and give it to a staff member. All medications must be dispersed by a staff member. Please do not leave medication in the possession of your child or in his/her lunch box. Let us know if the medication needs to be stored in a special way, i.e. in the refrigerator, or away from sunlight.

Medication to be administered at Program:			
Reason for Medication:			
Dosage:		Time:	
Start Date:		Stop Date:	
Method of Administration		Possible Side Effects	
Special Handling		Comments or Further Instructions	

Medication to be administered at Program:			
Reason for Medication:			
Dosage:		Time:	
Start Date:		Stop Date:	
Method of Administration		Possible Side Effects	
Special Handling		Comments or Further Instructions	

Medication to be administered at Program:			
Reason for Medication:			
Dosage:		Time:	
Start Date:		Stop Date:	
Method of Administration		Possible Side Effects	
Special Handling		Comments or Further Instructions	

Please list the medication your child takes outside of program hours, either at home or school:

Medication at Home	Med #1: Med #2: Med #3:	Dosage		Time	
Possible Side Effects					
Comments or Further Instructions					

Medication at School	Med #1: Med #2: Med #3:	Dosage		Time	
Possible Side Effects					
Comments or Further Instructions					

Physician Signature _____ Date _____

Physician Printed Name _____ Phone _____

I authorize the program staff to administer the above 'Medication at Program' medication(s) and/or treatment(s).

Parent/Guardian Signature _____ Date _____

Parent/Guardian Printed Name _____

(For Office Use Only)

Medication Log: Child's Name _____ Page 1 of_____

Date	Administered by Whom	Time Given	Medication	Dosage	Notes

*See additional attached pages for log continuation

Medication Log Continued: Child's Name _____ Page 2 of_____

Date	Administered by Whom	Time Given	Medication	Dosage	Notes

Date	Administered by Whom	Time Given	Medication	Dosage	Notes