# Medication Dispensing Authorization Form

**Name of Participant:** _____

| Name of Medication | Dosage | Time of day to administer | Administered how? *Ie) 2x daily, with food, etc.* | Time Period | |
|---|---|---|---|---|---|
| | | | | From | To |
| | | AM☐ PM☐ | | | |
| | | AM☐ PM☐ | | | |
| | | AM☐ PM☐ | | | |
| | | AM☐ PM☐ | | | |

**Additional information:**

_____

**Medication Location** (check one)**:** ☐ To be kept on site ☐ Sent home daily

**Medication Storage** (check one)**:** ☐ Room temperature ☐ Refrigerate

☐**Permission to self-carry and self-administer:** ONLY IF this medication is: 1) indicated for emergency administration to treat a disease/medical condition, and 2) in your professional opinion as a health care provider, it is appropriate for the student to carry and self-administer, and 3) the child has received instruction on how and when to administer.

**I, _____***(print name of parent/guardian),* **hereby authorize administration of the above medication(s) to my child by the Washington Township Parks and understand the following:**

*This authorization is valid only for this current program. This form must be completed in full for the Explorer Extended Care staff to administer medication to your child. A new medication administration form must be completed at the beginning of each program, for each medication, and each time there is a change in dosage or time medication is given.*

- *All medication **must** be in the original container with the student's name and current dosing information on the label.*
- *Non-FDA approved medication will not be dispensed during program hours. This includes, but is not limited to, vitamins, essential oils and homeopathic medications.* • A doctor's note is required if the medication is over the counter and given at a dose higher then listed on the label or for permission to self-carry and self-administer at school for chronic medical conditions

**Guardian Signature:**_____ **Date:**_____

| MEDICATION CHECK-IN | | | MEDICATION CHECK-OUT | | |
|---|---|---|---|---|---|
| **DATE** | **TIME- IN** | **INITIALS** | **DATE** | **TIME- OUT** | **INITIALS** |
| | | | | | |
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## Medication Administration Log

Name of Participant: _____

| Date | Time | Medication & Dosage given | Notes | Initials of Staff Administering |
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