

Authorization to Administer Medication – Lynden Sculpture Garden

Medication Information and Authorization Form

A copy of this form will accompany the medication during program. Please complete one form for each medication.

A. CHILD INFORMATION

Child's Name: _____

Birthday: (MM/DD/YYYY): _____

B. MEDICATION INFORMATION

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- My child will not bring any medications to Lynden's programs.

Medication shall be in original container and labeled with child's name. The label shall include dosage and directions for administration.

Name -Medication:

Over the Counter Medication (OTC): Does the OTC medication label indicate that the child's physician should be consulted? Yes _____ No _____ (if YES, I have consulted with my child's physician, and I am authorizing a dosage consistent with the physician's recommendation)

Parent initials: _____

Dosage:

Who Can Administer: _____ Staff _____ Child

Event Medication Should to be Administered (epi-pen, and other emergency medications):

...Or Time(s) of Day Medicine Should to be Administered:

____:____ AM ____:____ PM

____:____ AM ____:____ PM

____:____ AM ____:____ PM

____:____ AM ____:____ PM

Dates (Medication time period):

M:____/____/____ T:____/____/____ W:____/____/____ TH:____/____/____ F:____/____/____

How to be Administered:

Additional Information:

C. AUTHORIZATION

I hereby authorize Lynden Staff to administer the above medication to my child.

SIGNATURE (Parent / Guardian): _____ Date: _____

DOCUMENTATION OF ADMINISTRATION (Lynden staff use only)

Date Administered	Time Administered	Dosage	Signature of person who administered meds
1			
2			
3			
4			
5			