RISE After-School Program Medical Authorization Form

Name of Child: _____ DOB: _____

Name of Medication: _____

Reason for Medication: _____

Dose: _____ Time/Frequency: _____

Route -- Circle One: Oral Topical Inhaled Injection Other

Date to Start: _____ Date to Stop: _____ Expiration: _____

Additional Instructions/Comments:

_____

_____

Known side effects:

_____

For Prescription Medication

Prescribing Health Care Provider: _____

Phone Number: _____

I authorize the Effingham Public Library personnel to administer the medication named above to my child in the manner as stated. I release any liability in relation to the administration of this medication. I also acknowledge that, I, the parent/guardian, have given the first dose of this medication without any allergic or unexpected reactions.

Parent/guardian printed name: _____ Date: _____

Parent/guardian signature: _____

Return or Disposal of Medication

Return Date: _____ Parent signature: _____

Disposal Date: _____ Staff signature: _____