Municipality of the District of St. Mary's

Before and After Program
Medication Administration Permission Form

Please fill out this form in its entirety to give permission to Before and After Program staff to administer medication to your child. Please go over this form with staff to ensure that they understand the full instructions and can ask any questions if need be. All medication that parents wish to be administered need to be labelled with child's name in be kept in an appropriate container.

Child's Name: _____ Age: _____

Physicians Name: _____ Physician's Number: _____

Name of Medication(s): _____

Amount(s) to be Given: _____

Date(s) and Time(s) to be given: _____

_____

Special Instructions: _____

_____

_____

Medication Storage:_____

Start Date: _____ End Date: _____

Possible Side Effects: _____

_____

Stop medication if the following reaction is observed:_____

_____

Additional information/comments: _____

_____

Parent Signature: _____ Date: _____

Medication Record

Date	Time(s)	Amount	Given By (Initials)

Comments:

_____

_____

_____