Medication Authorization Form - Prescription Medication

Name of Child: ____ D.O.B.: _______________ Today's Date: _______

Name of Medication: ____

Prescribing Health Care Provider: ____Phone: __________________

Reason for Medication (optional):____

Dose: ________________________ Time/Frequency: ____

Route: ☐ Topical ☐ Inhaled ☐ Epi-Pen Injection

Check one: ☐ Child will self-administer in presence of adult ☐ Staff to administer to child

Date to Start: __________________ Date to Stop: ___________________ Expiration: ___________________

Additional Instructions/Comments:

____

____

Known side effects:____

I authorize (camp registered at) ____ personnel to administer the medication to my child as stated above. I release and agree to hold the City of Shaker Heights, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Parent/guardian printed name: ______________________________________Date signed: ________

Parent/guardian signature:

____

Return of Medication to Parent/Guardian:

Return Date: _____________ Parent/Guardian Printed Name:____________________________

Parent/Guardian Signature:____

Date_____________________________

CITY OF SHAKER HEIGHTS | *Recreation*

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