APPENDIX A

AUTHORIZATION FOR DRUG/MEDICATION ADMINISTRATION

Whitestone After School Program

This form must be completed by the parent of a child who is requesting that a drug or medication be administered during hours that the child receives child care, in accordance with the child care centre's medication administration policy and procedures.

Child's Full Name:

Child's Date of Birth (dd/mm/yyyy)**:**

Date Authorization Form Completed (dd/mm/yyyy)**:**

Date Authorization Form Updated (dd/mm/yyyy)**:**

Name of Drug or Medication (as per the original container label):	
Date of Purchase or Date Dispensed:	
Expiry Date:	
Authorization Start Date:	
Authorization End Date:	

Method of Medication Administration (initial below)

☐ The After School Program Provider is to administer the drug or medication to my child. ____

☐ My child will self-administer the drug or medication (optional, for children who attend school only). ____

Authorization for Child to Carry Emergency Allergy Medication

☐ I authorize my child to carry their own asthma medication.

☐ Not applicable (this authorization is not for asthma medication).

Medication Administration Schedule

☐ The drug or medication needs to be administered according to the following schedule:

Day(s) of the Week	Time(s) of the Day / Intervals	Amount/Dosage	Additional Information (where applicable)

APPENDIX A

AND/OR, where drugs are to be administered on an 'as needed' basis:

☐ The drug or medication needs to be administered when the following physical symptoms are observed:

Amount/Dosage:

Parent/Guardian Authorization Statement:

I hereby authorize the Program Coordinator in charge of drugs or medications at the Whitestone After School Program to administer the above-named drug or medication to my child and handle the drug or medication in accordance with the procedures I have provided on this form.

I understand that expired drugs or medications will not be administered to my child at any time in accordance with the child care centre's medication administration policy.

I understand that the Program Coordinators at the Whitestone After School Program are not medically trained to administer drugs and medications.

Print name:	**Relationship to Child:**
Signature:	**Date Signed:** (dd/mm/yyyy)

Received By:

Print name:	**Role at Child Care Centre:**
Signature:	**Date Signed:** (dd/mm/yyyy)

For After School Program Use Only

Location medication will be stored:

For Office Use Only

Date Drugs/Medication Returned to Parent / Pharmacy (dd/mm/yyyy)**:**