4-H Afterschool Program

Authorization for Administration of Medication at 4-H

Youth Name _____

This portion to be completed by physician/dentist:

Medication will be given to a 4-H Afterschool and Summer Program participant only when absolutely necessary. Whenever possible, the patient and physician/dentist are urged to design a schedule for giving medication outside of program hours. If this is not possible, it must be understood that the Lead Teachers or a designated Program Assistants will administer the medication. The 4-H Afterschool and Summer Program accepts no responsibility for untoward reactions when the medication is given in accordance with the directions of the children's physician/dentist.

Name of medicine: _____
Dosage: _____
Times to be given: _____
How administered: _____
Storage of medication: _____
Reason for medication: _____
_____
Length of prescription period: _____
Possible side effects of medication: _____
_____

I certify that a valid health reason exists requiring that this medication be administered during such time that the child is under the supervision of 4-H Afterschool and/or Summer Program employees. I request and authorize that the above named youth be administered the above medication in accordance with the instructions indicated. I will be monitoring the ongoing health of this patient.

_____ _____
Physician/Dentist Print Name Phone Number

_____ _____
Physician/Dentist Signature Date

Pamela Roberts
Jefferson County 4-H Coordinator
201 W. Patison
Port Hadlock, WA 98339
360-379-5610 ext. 207

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I certify that I am the parent, legal guardian, or other person in legal control of the above-named youth. I have read this form and request and authorize program staff to administer the medicine prescribed. The medication is to be furnished by me in the ORIGINAL prescription container.

I also agree that because of the program's schedule and other responsibilities of staff, it is permissible for dosages to be delayed or missed. If there is any medication remaining at the end of the program, it will be destroyed if I do not pick it up by the last day of the program. You have my permission to communicate with this physician/dentist.

I understand that my signature indicates that staff accepts no liability for untoward reaction when the medication is administered in accordance with the physician/dentist's direction.

_____

Parent/Guardina Signature Date