REQUEST FORM FOR ADMINISTRATION OF PRESCRIPTION MEDICATION DURING KIDS CLUB / HIVE TIME

Parents or Guardians of children requesting that medication be administered during Kids Club/Hive Time hours by Site Supervisor or trained individual are required to provide for Kids Club/Hive Time: 1) Physician's order for administration or 2) a parental request for the administration of medication.

Parent/Guardian complete the following information per MN DHS policies

Child's Name:________________________________Grade:_____________________Birthdate:________________
Childcare Site:________________________________
Parent/Guardian Name:____
Home Address:____
Description of Health/Medical Concern or Allergy:
____
____
Is this health/medical condition or allergy life threatening? Yes or No
What triggers (if any) are associated with your child's health/medical concern or allergy?________________________
____
Best techniques to avoid an allergy reaction:____
Symptoms of an allergic reaction specific to your child:____
Procedure for how to respond to allergic reaction or health/medical concern:
____
____

Physician's order for administration of medication by Kids Club / Hive Time

I have prescribed the following medication for this child and request the dosage given during Kids Club/ Hive Time hours be administered by the Site Supervisor or trained individual.

Diagnosis:____ Medication:__________________________________
Dosage and time:____
Physician's Name (print):____
Physician's Signature:____
Physician's Address:____ Phone:__________________________

Parental request for administration of medication

I request this medication be given as prescribed. I release Kids Club/Hive Time personnel from any liability in relation to the administration of this medication at Kids Club/Hive Time. I authorize the exchange of information regarding these medications between the clinic and the Kids Club/Hive Time for the duration of the year. Medication provided to the site should be provided in the original container, labeled with your child's first and last name, and not expired.

Parent/Guardian Signature:____Date:_____________________
Diagnosis:____Name of Medication:____________________________
Administering Instructions:____
Dosage and time:____
Physician's Name (print):____
Physician's Address:____ Phone:__________________________

<u>For Staff Use Only:</u>

ALWAYS review the written Parent/Guardian medication instructions and/or Health Care Provider's medical order prior to EVERY administration.
7 Rights MUST be performed with EVERY dose! Right **child**, right **medication**, right **dose**, right **route**, right **time**, right **reason**, right **documentation**.

Date Given	Time Given	Dose Given	Route Given	Comments/reactions	Staff Full Signature	Printed Staff Full Name