

# KAFRC - Administration of Medication: Permission Form & Log Sheet

**To be completed by PARENT/GUARDIAN.**  
Please print clearly and complete all sections.

Parents should consult with their child's doctor to ensure that the medication schedule allows their child to receive all prescribed doses of medication AT HOME, whenever possible. The first dose of any medication **MUST** be taken at home.

- Completion of this form authorizes KARFC to administer the prescription medications listed below.
- **KAFRC reserves the right to refuse requests to administer medication or discontinue administration of a medication to a child if any of the criteria of the policy are not met.**
- Medication must be delivered to KARFC by a responsible adult in the container in which it was dispensed by the pharmacy. If the medication or dosage is changed, a new form must be completed.
- "Over the counter" medication will be administered for a maximum of 2 consecutive days.

### CHILD'S INFORMATION

Child's Name:

Today's Date:

### MEDICATION INFORMATION

Medication Name:

Drug Identification Number (DIN):

Prescription    or     Over the counter (2 day max)

Diagnosis:

Tablet/Capsule

Liquid

Inhaler/Nebulizer

Injection

Cream

Other

### INSTRUCTIONS:

Dosage:

At specific time(s)

Time 1: \_\_\_\_\_ am pm

Time 2: \_\_\_\_\_ am pm

Time 3: \_\_\_\_\_ am pm

When these symptoms are present:

Symptom 1: \_\_\_\_\_

Symptom 2: \_\_\_\_\_

Symptom 3: \_\_\_\_\_

**Start Date**

DD    /    MM    /    YYYY    -    -    -    -

**Stop Date or  
Expiry Date**

DD    /    MM    /    YYYY    -    -    -    -

Indicated start date differs from date on prescription label

I \_\_\_\_\_ (initials) am confirming that the first dose of the prescribed medication was given on \_\_\_\_\_.

***I hereby authorize the Kemptville Area Family Resource Centre staff to administer the above medication to my child.***

Parent/Guardian Signature:

\*By typing your name in this box, you agree to the above statement

### EDUCATOR ONLY SECTION

all sections of this form have been completed by parent/guardian and verified by you  
 different start date has been noted & initialed if applicable

dosage indicated matches prescription label  
 cream has been noted in log book for other staff to see

medication is in original container & labeled with child's name  
 medication is secured in lock box

Staff Signature:

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Date:	Time:	Name of Medication	Dosage:	Staff Name:	Staff Signature
Observation:					<input type="checkbox"/> recorded in HiMama <input type="checkbox"/> recorded in log book
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