A. REQUEST OF ADMINISTRATION OF MEDICATION:

Name: ___________________________________ Date of Birth: _______________________

Parent/Guardian:___________________________

Address____

Telephone Home: __________________Cell:______________________ Bus.: ______________________

Physician:_____________________________________ Physician's Telephone:_____________________

B. PARENT/GUARDIAN AUTHORIZATION:

1. Name of Medication: ____
2. Patient Allergies: ____
3. Form: ____________________________ 4. Route: ____
5. Restrictions: ____

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6. Dosage and time to be given: __________________ ____________________ __________________
7. Storage caution (if any):____
8. Duration of Medication Regime____
9. Caution or noticeable side effects____

I am/ We are the parent/guardian of_________________________________. I/We hereby request that the above "Name of child medication", using the procedure(s) as outlined above, be administered to my/our child by Teamworks Dufferin staff. I/We hereby acknowledge that I/We have filled out the form to the best of my/our knowledge and that the container and medications are identical and the medication is up to date.

Signature:____ Date:_______________________

A new form must be completed for any change in the above instruction.