



BOYS & GIRLS CLUB
OF ALBANY

Authorization for Medication Administration by Boys & Girls Club Personnel

Member Name: _____ DOB: _____
Grade: _____

I am giving Boys & Girls Club Personnel permission to administer medication/s to my child per the following:

Parents/Guardians Complete:

Medications: _____	Non Prescription _____
Dose: _____	Prescription Rx# _____
Frequency: _____	Please allow my child to self-administer this medication _____
As Needed _____	Mandatory Administration _____
Route: (Circle One)	
By: Mouth Ear Eye Nose Skin	
Time: _____	
Duration: Start date _____ End date _____	
Reason for Medication:	
Special Instructions:	

I understand I am responsible to provide this medication and maintain the supply as needed. I understand I am responsible to notify the Club in writing of any changes. Parents are required to pick up all unused medication by the last day of Club. All medication left at the Club will be discarded.

Parent/Guardian Signature: _____ Date: _____

(This authorization applies only to the medication listed above and for the duration of treatment or school year.)

Medications must be in the original container with the prescriptions label attached.