St. Vincent de Paul Family Success Center

PHYSICIAN'S REQUEST TO ADMINISTER MEDICATION

Participant's Name: _____

Name of Medication: _____

Dose: _____ Time: _____

Physician's Name: _____

Reason for Medication: _____

Possible Side Effects: _____

I am aware that St. Vincent de Paul's Family Success Center does not have trained medical staff available. However, the above-named participant is in need of the above-named medication/drug during the time frame of an after-school program in order to maintain his/her physical health. In my opinion, his/her need for the medication/drug is so important that I request that non-medical personnel dispense this medication/drug in accordance with the following instructions:

Child may self-administer in accordance with the instructions above: Yes/No? _____

In the event of possible side effects, please take the following action:

_____ _____

Date Doctor's Signature

_____ _____

Date Parent/Guardian's Signature

☐ **Please check the box to the left if the statement below applies to your child.**

My child does not currently take any medications that will need to be administered/taken during program time.

_____ _____

Date Parent/Guardian's Signature