McKENDREE METROREC PLEX

205 Rec Plex Dr. | O'Fallon, IL 62269
Tel: 618.589.3800 | MetroRecPlex.com

PLEXKIDS

Summer Camp

Childcare Medication Authorization Form

Name of Medication: _____

Reason for Medication: _____

Dose: _____ Time/Frequency: _____

Route: ☐ Oral ☐ Topical ☐ Inhaled ☐ Injection ☐ Other: _____

Date to Start: _____ Date to stop: _____

Expiration:_____

Additional Instructions/Comments: _____

Known side effects: _____

FOR PRESCRIPTION MEDICATION

Prescribing Health Care Provider: _____

Phone Number: _____

FOR CONTROLLED SUBSTANCES

Amount of Medication Received: _____

Staff Member Signature: _____

AUTHORIZATION

I authorize McKendree Metro Rec Plex personnel to administer the medication named above to my child in the manner as stated. I release any liability in relation to the administration of this medication. I also acknowledge that I, the parent/guardian, have given the first dose of this medication without any allergic or unexpected reactions.

Parent/guardian printed name: _____ Date: _____

Parent/guardian signature: _____

RETURN OR DISPOSAL OF MEDICATION

Return Date: _____ Parent Signature: _____

Disposal Date: _____ Staff Signature: _____

Witness to Disposal: _____