



Medication Authorization Form

I authorize the administration of _____ for my child

Medication name

_____ By Streetsville Children's Centre.

Child's first and last name

ADMINISTRATION INSTRUCTIONS: (As per the instructions on the original container or prescription)

Start date and time: _____ End date and time: _____

Purchase Date: _____ Expiry Date of Medication: _____

Time(s) of administration _____ am. and/or p.m.

Dosage: _____ Storage: _____

Child has had this medication before: Yes No

Possible Side Effects: _____

Discontinue medication if the following reaction(s) is observed:

I _____, my child, and my family waive all claims that we may have against Streetsville Children's Centre, its employees, operator and volunteers relating to:

1. Any harm to my child caused by the administration of this medication, and
2. The safety or effectiveness of this medication, alone or in combination with other medications for which I have signed a Medication Authorization Form.

I recognize that Streetsville Children's Centre is not a skilled professional in administering medications, and that it is relying entirely upon the directions printed on the medication and upon the directions set out in this authorization. I acknowledge that I have been strongly encouraged to seek the advice of skilled professionals (doctor, pharmacist) regarding the directions set out in this authorization and the safety and effectiveness of combining the medications set out in the authorization that I have provided to Streetsville Children's Centre.

Parent's Signature

Date

[Type here]

