BOYS & GIRLS CLUBS
OF GARDEN GROVE

# Parent Release / Physician's Request for the Administration of Medicine by Club Personnel

**PARENT RELEASE**

It is understood that the Club is not legally obligated to administer medication to our child and, therefore, we agree to hold the Boys & Girls Clubs of Garden Grove and its employees free from any and all responsibility for the results of such medication or the manner in which it is administered and to indemnify each of them against the loss by reason of any civil judgment arising out of these arrangements which may be rendered against them.
Medication shall be supplied by parent in an original pharmacy bottle.

We, the undersigned, parents of *(Name of Member)* _____ request that medication be administered to our child in accordance with the instructions on the form below signed by our physician *(Name of Physician)* _____. We understand that the other Club Personnel may administer the medication if the Club Branch Director is not available. We will notify the Club immediately if there is a change of physician or if there are any changes in the instructions.

**Parent / Guardian Signature** _____

**Parent / Guardian Signature** _____

**Address** _____

**Home #** _____ **Work #** _____

**Date** _____

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**PHYSICIAN'S REQUEST**

1. Physical condition for which drug is going to be given. (If allergic in nature, please specify what type of reaction, i.e.: localized, generalized, mild, severe)

   _____

2. Name of medicine _____

3. Dosage and method of administration _____

4. Possible reactions that need to be reported to the physician _____

   _____

5. Disposition of child following administration of medication, i.e: rest, return to activities at Club _____

   _____

6. Medication to be continued as above until *(date)* _____

7. The above medication cannot be scheduled for other than Club hours and such medication may be administered by medically untrained Club Personnel whenever necessary.

***Physician Signature** _____

**Address** _____

**Telephone** _____ **Date of Request** _____

**Physician's signature is required for all medications.*

# MEDICATION SCHEDULE

**Child's Name: _____**

**Medication Prescription #: _____**

**Amount: _____**

**Week of: ___/___/___ - ___/___/___**

| DAY | 11A - 12P | 3P - 4P |
|---|---|---|
| Monday | | |
| Tuesday | | |
| Wednesday | | |
| Thursday | | |
| Friday | | |

**Parent's Signature: _____**

**Director's SIgnature: _____**

**Date: _____**

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