

PRESCRIPTION MEDICATION PERMISSION FORM

BGC Office Use Only	
Date Received:	
Club Site:	

PHYSICIAN AND PARENT REQUEST FOR CLUB ADMINISTRATION OF MEDICATION

Club Member	Name: _				Date of Birth:		
TO BE COMPLETED BY AUTHORIZED HEALTHCARE PROVIDER Name of Prescription Medication:** (one per form)							
Form of Med							
_		_		-	□ Nebulizer □ Other:		
Instructions: (Schedule and dose to be given at club)							
Restrictions, Precautions, and/or Important Side Effects:							
□ Yes. Please	describe	:					
Special Stora	ge Requi	irements:	□ None	□ Refrigerate	□ Other:		
Duration:	Start:	□ Date form r	eceived	\Box Other date: _			
	Stop:	☐ At specified	l date:		□ At end of (year): 20		
The healthcare provider whose signature follows hereby authorizes club personnel to administer medication/treatment as prescribed and also agrees to accept communication regarding the administration procedures. It is understood that non-licensed, trained personnel may give the medication/treatment.							
Provider Name	e/Title (F	Print)	Prov	ider Signature	Date		
Address					Phone Number		
TO BE COMPLETED BY PARENT/LEGAL REPRESENTATIVE The club personnel have my permission to administer this medication/treatment as indicated above and according to club policy. Per WI N6.03 Nurse Practice Standards, the supervisor may consult with the provider if there are questions or concerns about the order.							
Parent/Legal Representative Signature				Date			

** ALL MEDICATIONS MUST:

- Be in ORIGINAL CONTAINER
- Include the CHILD'S NAME
- Be UNEXPIRED

- Be PICKED UP before the last day of the Enrollment Period
- Any meds LEFT after the end of the Enrollment Period will be discarded

Boys & Girls Club of Portage County Fax Number: 715.544.0845

Updated 02/17/2020

Note: This form is valid for one Enrollment Period (School Year or Summer Session)



NON-PRESCRIPTION MEDICATION PERMISSION FORM

BGC Office Use Only						
Date Received:						
Club Site:						

PARENT REQUEST FOR CLUB ADMINISTRATION OF MEDICATION

Club Member Name:		Date of Birth:				
TO BE COMPLETED BY PARENT/	LEGAL REPRESENTAT	IVE				
Name of Non-Prescription Medication	:** (one per form)					
Reason for Medication:						
Form of Medication/Treatment:						
□ Tablet/Capsule	□ Liquid □ □	Other:				
Instructions: (Schedule and dose to be given at club)						
Restrictions, Precautions, and/or Impo	ortant Side Effects:	□ None anticipated				
□ Yes. Please describe:						
Special Storage Requirements:	□ None □ Refriger	ate Other:				
Duration: Start: □ Date form rec	eived □ Other da	te:				
	ate:					
The club personnel have my permission to club policy.	to administer this medicatio	on/treatment as indicated above and according				
Parent/Legal Representative Signature	Date					

** ALL MEDICATIONS MUST:

- Be in ORIGINAL CONTAINER
- Include the CHILD'S NAME
- Be UNEXPIRED

- Be PICKED UP before the last day of the Enrollment Period
- Any meds LEFT after the end of the Enrollment Period will be discarded