Stratford Ecological Center
REQUEST FOR ADMINISTRATION OF MEDICATION

This form is valid for no longer than twelve (12) months. One form must be used for each medication.

Box 1 – The following section must **always** be completed by the parent/guardian.

Check all that apply:

- ☐ Prescription medication
- ☐ Nonprescription medication
- ☐ Refrigeration required
- ☐ Topical product or lotion
- ☐ Food supplement
- ☐ Modified diet

Complete all of the following information:

Name of child:_____ Date of birth:_____ Weight: _____

Child's address:_____ Precise dosage: _____

Dates and Class in which child is enrolled:_____

Name of medication: _____

Instructions for storage: _____

To be administered at the following times: _____

For the following period of time (beginning and ending dates): _____

Whom should the Stratford Ecological Center contact with information about severe adverse reactions:

Name: _____ Telephone No. _____

I acknowledge requesting that Stratford Ecological Center (SEC) administer medication to the above-named child. The medication and instructions therefore are as I have represented them to be. I/we release, indemnify and hold SEC and its employees and/or agents harmless from any harm allegedly arising from medication, food supplement or modified diet administered by SEC personnel or its agents. I acknowledge that SEC is not required to administer medications, food supplements or modified diets and does so purely for the benefit of the child so that he/she can participate in the program. I understand that I am required to furnish all requested information, including doctor's statements. I agree to obtain a new physician's statement if any of this information changes.

Parent/Guardian signature: _____ Date:_____

Box 2 – The following section must be completed by a **licensed physician, a licensed dentist or an advance practice nurse** certified to prescribe medications when:

1. The Rx or medication label does not contain all of the information required by Box 2; or
2. It is a sample medication without a prescription label; or
3. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period or is a topical product or lotion that is being used for a skin ailment and is to be applied longer than fourteen consecutive days; or
4. The child is on a modified diet (an entire food group is eliminated) or food supplement; or
5. The Rx label is not affixed to the original container.

_____ is under my care and is to receive _____
(name of child) (name of medication, vitamin, diet)

as follows: _____
(include dosage, time intervals and any special instructions)

Possible side effects or adverse reactions to watch for are:

_____

Expiration date: _____ (May not exceed 12 months from the date of this request for medications or food supplements)

_____ _____ _____
Signature of physician, dentist or advance practice nurse Date of signature Phone number

Box 3 – The section is to be completed by Stratford Ecological Center staff and each administration of medication will be documented.

_____ was given _____ in the amount of _____
(Name of Child) (Name of Medication, Vitamin or Diet) (Dosage)

Date and Time of Dosage	Dosage Amount	Signature of Designated Person Administering Medication