ROCKY MOUNTAIN MISSION CENTER

Community of Christ

NAME OF YOUTH: ______________________________ BIRTHDATE: _______________

I, the undersigned parent, legal guardian or next of kin, for my child, ask the Community of Christ staff give medication(s) to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

Prescription medications must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.

Over-the-counter medications must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

Preventive creams/ointments/sunscreen may be applied unless skin is broken or bleeding
_____ (initials)

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the authorized staff person delegated to administer medication.

________________________________ ________________________________ _______________
Print Parent/Legal Guardian's Name Signature of Parent/Legal Guardian Date

Day Phone: __________________________ Evening Phone: __________________________

HEALTH CARE PROVIDER AUTHORIZATION

Medication – Name: ______________________________
Dosage: _____________________________ Route: _____________________
Times to be given: ____
Special Instructions: ____
Side effects that need to be reported: ______________________________________

Medication – Name: ______________________________
Dosage: _____________________________ Route: _____________________
Times to be given: ____
Special Instructions: ____
Side effects that need to be reported: ______________________________________

_____________________________ _____________________________ _______________
Print Health Care Provider Name With Prescriptive Authority
Signature of Health Care Provider With Prescriptive Authority
Date

License Number: ________________ Phone: __________________________