

ST. PATRICK'S OUT OF SCHOOL CARE PROGRAM

MEDICATION CONSENT FORM

By signing below you give consent for the Out of School Care Program staff to administer emergency medications (i.e. Epi-pen, inhaler; provided by you) to your child.

Child's Name: _____

Allergy/medical condition: _____

Possible Symptoms: _____

Medication name/s: _____

Expiry date/s: _____ Dosage/s: _____

Location of medication: _____

If there are any changes to the above information, you must contact us immediately to update this form.

Failure to return this for the St. Patrick's Out of School Care Program will make it impossible for your child to receive the emergency medication he/she may require.

Date

Parent/Guardian Signature

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**FOR OUT OF SCHOOL CARE STAFF ONLY**

**DATE**

**TIME ADMINISTERED**

**DOSAGE**

**INITIALS**