2020 SPECIAL NEEDS MEDICATION AUTHORIZATION FORM

Contact Information (Please print clearly.)

Participant Name: _____ Date of Birth (mm/dd/yyyy): _____

Medication Policy

- If participant requires prescribed daily medication while attending a Clubhouse program, please complete this form.
- Please clearly note if your participant needs any assistance with their medication and if so, make arrangements to speak with the Activity Coordinator and Lead Team Counselor so appropriate arrangements can be made. Staff and volunteers are not permitted to provide or administer any kind of medication. Medication can be stored on site.

I, the undersigned, am a parent/guardian of the specified participant. I have read and fully understand the provisions of the above releases and explained them to the said participant.

Parent/Guardian Signature: _____

Printed Name of Parent/Guardian: _____

Date: _____

Medical Information

Use additional sheet if needed.

Medication Name: _____ Amount Taken: _____

Time or Frequency: _____

Administration: ☐ Takes Independently ☐ Needs Counselor Reminder ☐ Needs Counselor Supervision

Storage: ☐ Stores Independently ☐ Stored By Counselor

Special Instructions: _____

Medication Name: _____ Amount Taken: _____

Time or Frequency: _____

Administration: ☐ Takes Independently ☐ Needs Counselor Reminder ☐ Needs Counselor Supervision

Storage: ☐ Stores Independently ☐ Stored By Counselor

Special Instructions: _____

_____

Medication Name: _____ Amount Taken: _____

Time or Frequency: _____

Administration: ☐ Takes Independently ☐ Needs Counselor Reminder ☐ Needs Counselor Supervision

Storage: ☐ Stores Independently ☐ Stored By Counselor

Special Instructions: _____

_____

Medication Name: _____ Amount Taken: _____

Time or Frequency: _____

Administration: ☐ Takes Independently ☐ Needs Counselor Reminder ☐ Needs Counselor Supervision

Storage: ☐ Stores Independently ☐ Stored By Counselor

Special Instructions: _____

_____

Other Notes

_____

_____

_____

Office Use Only

Team Assignment: _____ Year/Session: _____

Note Date, Time and Action Taken:

_____

_____

_____

Return Completed Form

Form must be received prior to the start of the Clubhouse program.

Mail to:

City of Altamonte Springs
Attn: Rachel Barrett
225 Newburyport Avenue
Altamonte Springs, FL, 32701

Contact Information:

Email: RBarrett@altamonte.org
Phone: (407) 571-8812
Fax: (407) 571-8451