Grandview Children's Centre
600 Townline Road South
Oshawa, Ontario L1H 7K6
grandviewkids.ca

REQUEST FOR ADMINISTRATION OF MEDICATION

Name of Activity: ______________________________

Dates for which authorization applies: ______________________________

Client Name: ______________________________ Chart #: ____________

Birth Date: ____________ Parent/Legal Guardian: ______________________________

Address: ______________________________

Telephone: ____________________ Alternate Phone: ____________________

Physician: ____________________ Phone: ____________________

Physician Address: ______________________________

PARENT/LEGAL GUARDIAN AUTHORIZATION:

Medication(s):	1)	2)	3)	4)	5)
Dosage:	1)	2)	3)	4)	5)

I/We hereby request that the above medication and procedure as outlined, be administered to our child. It is understood that the staff person administering medication is doing so in the absence of a parent/legal guardian, and not as a health professional. In consideration of the administration of the above medication, I assume all risk of personal injury, death or property loss resulting from any cause whatsoever, other than the gross negligence or breach of statutory duty of care on the part of Grandview Children's Centre, it's agents, servants and employees. I/we agree that Grandview Children's Centre, it's agents, servants and employees shall not be liable to me, my child(ren) or our heirs or estate trustees for any such personal injury, death or property loss and release the said Grandview Children's Centre, it's agents, servants and employees and waive any and all claims with respect thereto. I/We agree that the information contained herein is correct. I/We further agree that if there is a change in information and/or medical condition of my/our child(ren), I/We will inform Grandview Children's Centre immediately of such change.

______________________________ ______________________________
Date Signature of Parent/Legal Guardian

______________________________ ______________________________
Signature of Physician (for non-prescription Medication administered more than 7 days) Signature of client (if over 16 years of age)

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MEDICATION LOG #1

Client Name: ____ Chart #:__________________

Birth Date: ______________________________ Phone: _______________________________

Allergies:____

Date	Drug Name/Description	Dose Amt/Time	Route (eg oral)	Storage/Side Effects/ Instructions	Time Given	Administered	
						Staff	Witness

Completed by: (Client/Parent/Legal Guardian) ______________________ Date: ____________________

Reviewed by: (Client/Parent/Legal Guardian) _______________________ Date: ____________________

Reviewed by: (Grandview Staff or RN if applicable)___________________ Date: ____________________

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MEDICATION LOG # 2
NARCOTICS/STIMULANTS

Client Name:______________________________________Chart #:________________ Birth Date: ____________________ Phone: ________________

Allergies: ____

Date	Drug Name/Description	Amt. Rec'd	Counted		Dose Amt. / Time Witness	Route (e.g. oral)	Storage / Side Effects / Instructions	Time Given	Administered		Amt. Returned		Comments / Inadvertent Losses
			Staff	Witness					Staff	Witness	Staff	Witness	

Completed by: (Client/Parent/Legal Guardian) ____ Date: ______________________
Reviewed by: (Client/Parent/Legal Guardian) ____ Date: ______________________
Reviewed by: (Grandview Staff or RN if applicable) ____