



Panther Academy After-School Program,
University of Prince Edward Island Chi-Wan Young Sports Centre, 550 University Avenue
Charlottetown, PE C1A 4P3
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Administration of Medication Consent Form

Child's Name: _____

- ☐ Medication may be **self**-administered by the child
☐ Medication **must** be administered by the Program Designate

I, _____ authorize the administration of (name of medication)
_____ to (child's name)
_____ for (reason) _____ by the
Coordinator or Designate staff member designated by the Coordinator.

Date medicine started: ____ \ ____ \ ____ (Month \ Day \ Year)

Medicine end date : ____ \ ____ \ ____ (Month \ Day \ Year)

Dosage: _____

Times of Administration:

1. _____ 2. _____
3. _____ 4. _____

Is *refrigeration* required? Yes ____ No ____

Special Instructions: (e.g. "Must be taken with food.")

Side effects:

Stop medication if the following reaction(s) observed:

Has this medication been prescribed by a physician: Yes ____ No ____

If yes, prescribing physician's name: _____ Phone Number: _____

Parent/Guardian's Signature: _____ Date: _____

PLEASE FILL OUT FORM COMPLETELY

Prior to administering, medication must be authorized by Director, Supervisor or designate.