Varsity Community Association
Medication Release Form

I hereby authorize the staff of the Varsity Child Care Programs

Child's Name: _____ Name of Medication: _____

Prescription #:_____ Expiry Date: _____

Start Date: _____ Finish Date: _____

Time to be given: _____ Amount: _____

Doctor's Name: _____ Phone # _____

Special Instructions: _____

PLEASE ENSURE THAT ALL MEDICATION IS RECEIVED IN THE ORIGINAL CONTAINER AND CHECK FOR CORRECT MEDICATION AMOUNT

All medications are kept in Medicine Box. No medication is to be kept in the child's cloak room area.

_____ _____
Signature of Parent or Guardian Date

_____ _____
Signature of Staff Receiving Medication Date

_____ _____
Name of person medication was returned to Name of person returning

_____ _____
Date of return Reason returned

_____ _____
Name of person medication was returned to Name of person returning

_____ _____
Date of return Reason returned

_____ _____
Name of person medication was returned to Name of person returning

_____ _____
Date of return Reason returned