ADMINISTERING MEDICATION PERMISSION FORM

We/I ___________________________ give permission to the respite worker to administer the

following prescribed medications to _____________________.

Medication Name	Dosage	Time(s) to Administer

____
Parent/Guardian/Individual Signature

____
Respite Worker

____
Date

Family Respite Services. (2014). Respite Contract. In *In Home Handbook*. Retrieved from http://www.familyrespite.org/handbooks

MEDICATION ADMINISTRATION LOG

Time Medication Given	Name of Medication	Dosage	Initials

Family Respite Services. (2014). Respite Contract. In *In Home Handbook*. Retrieved from http://www.familyrespite.org/handbooks

MEDICAL EMERGRNCY INFORMATION

Name: ______________________ D.O.B.: ____________

Parent's Names: ______________________

Address: ______________________

Phone Number (H): ____________ Phone Number (W): ____________

Resides with: ______________________

Child's Doctor's Name: ____________ Doctor's Phone: ____________

Health Card : ____________ Religion: ____________

Emergency Contact Person: ______________________

Relationship to Child: ______________________

Address: ______________________

Phone Number (H): ____________ Phone Number (W): ____________

Current Medications: ______________________

____

Medical Cautions/ Communicable diseases: ____________

____

Allergies: ______________________

______________________ ____________
Parent/Guardian/Individual Signature Date

______________________ ____________
Respite Worker Signature Date