girl scouts of western washington

Administering Medications to a Minor

Written authorization and instruction from medical provider in regard to administering medications

I am familiar with the medication condition of_____ [name of Girl Scout], who is a patient of_____ [name of office or clinic]. I understand that the purpose of this form is to allow a Girl Scouts of Western Washington volunteer to administer medication to the above named girl, and believe that he or she should be able to follow the instructions listed below without any further training and without detriment to the Girl Scout. _____ [name of Girl Scout] has the condition(s) set forth below that require that she take medication that has been prescribed by this clinic or by me. The volunteer who administers the medication should keep it in its original, marked container, should store it out of reach of other children, and should give the Girl Scout the medication in the dosage and according to the schedule set forth below:

Medical Condition	Name of Medication	Dosage	When and how often dose is administered	Special Storage Requirements (i.e. refrigerator, etc.)

Are there any OTC medications that are contraindicated for this Girl Scout? ☐ **Yes** ☐ **No** If Yes, please list below:

_____

If the volunteer has any questions or observes the Girl Scout having any of the following symptoms, the volunteer should contact this office or another qualified medical provider **immediately**.

_____

_____

Signature of Physician: _____ *Date:* _____

Name (Print): _____ *Title:* _____

Phone Number: _____ *Emergency Number:* _____