

Authorization to Administer Prescribed and/or Over-the-Counter Medication

We, the parents/legal guardian of _____, grant the Leaders of the 11th Toronto Group, or their designate, to administer the following listed medications to our child during the period of _____ to _____.

Medication Name	How Often (E.g. every 4 hours)	When (Before/After Meal, bedtime)	Dose (E.g. 5 ml.)	How to Administer (E.g. by mouth)
1.				
2.				
3.				
4.				

Conditions that may require attention:

The medications _____ are prescribed by Dr. _____ Tel. No. _____

The medication _____ are purchased over-the-counter from a drug store without a prescription.

Parent/Legal Guardian

Signature

Date

Cell phone No.

Alternate Contact Tel. No,

Youth's Health Card No.

Authorization to Administer Prescribed and/or Over-the-Counter Medication

本人為右列多倫多第十一旅小童軍團團員_____的父母/合法監護人。本人現授權多倫多第十一旅領袖或其指定人員, 在_____年____月____日至_____年____月____日期間代表本人給予上述小童軍團團員下列藥物。

藥物名稱	次數 (例如：每四小時一次)	時間 (例如：飯前、飯後)	劑量 (例如：5 ml.)	方法 (例如：口服)
1.				
2.				
3.				
4.				

請注意以下情況:

右列藥物_____是由_____醫生處方。 醫生聯絡電話:_____

右列藥物_____由藥房購買未經醫生處方。

父母/合法監護人

父母/合法監護人簽署

日期

手提電話號碼

其他聯絡電話號碼

小童軍安省保健咭號