



BOYS & GIRLS CLUBS
OF THE FOX VALLEY

Note: Return the completed form to the caregiver or the Boys & Girls Clubs of the Fox Valley.

160 South Badger Avenue, Appleton, WI 54914

Boys & Girls Clubs FAX #: 920-968-2716

HEALTH SERVICES
ADMINISTRATION OF MEDICATION CONSENT

Physician Statement*

One form for each medication given at Boys & Girls Club

Club Member Name: _____

DOB: _____

Medication Name**/Strength: _____

Dosage:** _____ Route:** _____ Frequency: _____
(in mg, ml, etc.)

Starting Date: _____ Termination Date: _____

Reason for Medication: _____

Precautions, possible untoward reactions, and/or interventions: _____

Prescribing physician name: _____

(please print)

Phone: _____

FAX: _____

Address: _____

(Signature of Physician)

(Date)

*Form to be **completed by R.N. or M.D. and signed by M.D.** – one medication per form

****A new physician statement will be needed for any changes in medication, dosage, route, or frequency.**