Foundation For Youth

405 Hope Ave.
Columbus, IN 47201
(812) 348-4558
www.foundationforyouth.com

To: FFY Personnel

Re: Administration of Medication to ________________________________
Member Name

This notice is to inform you that the above named child, enrolled in your program, is currently under my medical care. As part of that care, this child must be receiving the following medication for the medical indication listed, at the dosage, route and interval prescribed below.

Indicated Medical Diagnosis: ____

Medication: ____

Dosage, Interval and route: ____

Additional information:

____

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Problems concerning administration of this medication can be referred to me at:

_________________________________ _____________________________
Date Physician's Signature

_________________________________ _____________________________
Address Telephone

I, as the parent/guardian of ____, request authorize and give written permission to you to administer the medication described in accordance with the instructions provided.

I agree to notify you immediately of any change in circumstances concerning administration of this medication.

Parent Signature: ___________________ Address: __________________________

Telephone: (   )___________________ Date: __________________________

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Medication Policy: Parents of members will be asked not to send medications, unless for a life threatening condition or serious medical condition. Parents are welcome to come to FFY and give the medication to their member(s) if necessary. In the case that medication is necessary a form must be completed with physician's signature and original bottle must accompany medication. Over the counter medications will be administered only in special situations approved by program director.