



GREAT LIGHT HEALING COMMUNITY SERVICES SOCIETY

12057 88th Ave, Surrey, BC V3W 3J3



www.glhcommunityservices.org



info@glhcommunityservices.org



(778) 328-7729

Permission to Administer Medication Form

DATE: _____

I hereby give my permission to the staff at EASI JK Program to administer:

(Name of Medication) (Prescription Number)

to my child _____ according to the doctor's orders and
(Full Name of Child)

instructions. These instructions will be on the vial or bottle for prescription drugs and on the **Request for Administration of Non-Prescription Medication Form** for non-prescription drugs.

Full Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

MEDICATION RECORD

NAME OF CHILD: _____ PHYSICIAN _____

NAME OF MEDICATION: _____

DATE COMMENCED: ___/___/___ DATE STOPPED: ___/___/___

DATE	TIME	DOSAGE	COMMENTS	STAFF SIGNATURE

NOTE: One form for each prescription or refill.
Completed form filed in child's file.

OUR VISION

EMPOWERING INDIVIDUALS FROM ALL WALKS OF LIFE, THROUGH RESTORATIVE SERVICES,
IN ORDER TO MAKE HOLISTIC APPROACH TO CARE MORE SUCCESSFUL AND ACHIEVABLE.

OUR MOTTO

PERFORMANCE, PRODUCTIVITY, RESULTS & GLOBAL IMPACTS



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Request for Administration of Non-Prescription Medication Form

A. TO BE COMPLETED BY PARENT OR GUARDIAN:

NAME OF CHILD: _____ BIRTHDATE: ____/____/____

NAME OR GUARDIAN: _____

PHONE: (CELL) ____ - ____ - ____ (HOME) ____ - ____ - ____ (WORK) ____ - ____ - ____

PHYSICIAN NAME: _____ PHONE: ____ - ____ - ____

B. TO BE COMPLETED BY PHYSICIAN:

CONDITION WHICH MAKES MEDICATION NECESSARY:

NAME OF MEDICATION: _____

DOSAGE: Pills _____ Drops _____ Tsp. _____ Ounces _____ Mls. _____

TIME: A.M. _____ P.M. _____ DATE TO START: ____/____/____

TO BE GIVEN WITH: _____ (Water, Milk, Juice) DATE TO GIVE LAST DOSE: ____/____/____

ADDITIONAL COMMENTS : (Possible Reactions, Consequences of Missing Medication, etc.)

DATE: ____/____/____

SIGNATURE OF PHYSICIAN: _____

PHONE NO.: ____ - ____ - ____

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