YOUTH FLIGHT MEDICATION PERMISSION

MEDICAL LOG *(Youth Flight Activities Use Only)*	DATE *(YYYYMMDD)*

AUTHORITY: 10 USC 8013, Secretary of the Air Force: Powers and duties; delegation implemented by DODI 6060.2 and AFI 34-701, Child Development Programs/AFI 34-801, Youth Programs. PURPOSE: To record essential information from parent to administer medication to child. ROUTINE USE: None. DISCLOSURE IS VOLUNTARY: Furnishing this information is voluntary; not putting all or part of the information will prevent the administering of medication.

MEDICATION PROCEDURES

1. Parent or guardian must complete this form giving written permission for medication and have clinic staff complete appropriate section.
2. The Youth Flight Activity will administer only current prescription drugs, labeled with the child's name, name of medication, dosage strength and dosage schedule.
3. Medication will never be given after the expiration date, nor to an individual other than shown on the label.
4. The record of administration of medication will be kept at the Activity for one year.
5. Because of the possibility of reactions, the Activity will not administer the first dose of medication. Parents or guardian must administer the first dosage and wait twenty minutes before the child may be signed in. Patents must be made aware that adverse reactions can occur anytime during treatment.
6. Only qualified staff, approved by Youth Flight chief and trained by base medical staff, will administer medications.
7. Parents or guardian will be responsible for furnishing all supplies and will submit all changes to medical instructions in writing, signed by a health care professional. Parents must initial and date this form each day medications are given.

NAME OF CHILD:

CLINIC USE ONLY *(Clinic use is optional if prescription is within 30 days of being issued or can be read on the label.)*

It is essential that the above named child receive the medication(s) listed below.

MEDICATION	PURPOSE	PRESCRIPTION NUMBER	EXPIRATION DATE	DOSAGE	TIMES	STOP DATE

SPECIAL INSTRUCTIONS

NAME OF DIAGNOSING PROVIDER	*DATE SEEN (YYYYMMDD)*

ACTIVITY USE ONLY

DATE	MEDICATION	DOSAGE	TIME	SIGNATURE	DATE	MEDICATION	DOSAGE	TIME	SIGNATURE

STATEMENT OF PARENT OR GUARDIAN

I give permission for authorized staff at the _____

Air Force Base Youth Flight Activity staff to administer the medication(s) listed above.

SIGNATURE	DATE *(YYYYMMDD)*

DAILY PERMISSION VERIFICATION *(Initial and date)*
