

**Varsity Community Association  
Medication Release Form**

**Varsity Preschool**

**Varsity Out of School/Kinder**

I hereby authorize the staff of the Varsity Child Care Programs

Child's Name: \_\_\_\_\_ Name of Medication: \_\_\_\_\_

Prescription #: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

Start Date: \_\_\_\_\_ Finish Date: \_\_\_\_\_

Time to be given: \_\_\_\_\_ Amount: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Special Instructions: \_\_\_\_\_

**PLEASE ENSURE THAT ALL MEDICATION IS RECEIVED IN THE ORIGINAL CONTAINER  
AND CHECK FOR CORRECT MEDICATION AMOUNT  
All medications are kept in Medicine Box. No medication is to be kept in the child's cloak room area.**

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Staff Receiving Medication

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of person medication was returned to

\_\_\_\_\_  
Name of person returning

\_\_\_\_\_  
Date of return

\_\_\_\_\_  
Reason returned

\_\_\_\_\_  
Name of person medication was returned to

\_\_\_\_\_  
Name of person returning

\_\_\_\_\_  
Date of return

\_\_\_\_\_  
Reason returned

\_\_\_\_\_  
Name of person medication was returned to

\_\_\_\_\_  
Name of person returning

\_\_\_\_\_  
Date of return

\_\_\_\_\_  
Reason returned