Permission for Medication Administration at School and Child Care

The parent/guardian of _____ ask that school/child care staff give the
Child's Name

following medication _____ at _____
Name of Medicine & Dosage *Time(s)*

to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

Prescription medications must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, route, date medicine is to be stopped, and licensed Health Care Provider's name. Pharmacy name and phone number must also be included on the label.

Over the counter medication must be labeled with child's name. Dosage must match the signed Health Care Provider authorization, and medicine must be packaged in original container.

The school/child care agrees to administer medication prescribed by a licensed Health Care Provider with prescriptive authority. The parent agrees to pick up expired or unused medication within one week of notification by staff. All medication(s) left at the school will be discarded according to the most current state regulatory recommendations for safe medication disposal.

By signing this document, I give permission for my child's Health Care Provider to share information about the administration of this medication with the school staff delegated to administer medication.

_____ _____ _____
Parent/Legal Guardian's Name Parent/Legal Guardian Signature Date

_____ _____
Work Phone Alternate Phone

****

Health Care Provider Authorization

Child's Name:		Birthdate:
Medication:	Dosage:	Route:
To be given at the following times:	Start Date:	End Date:
Special Instructions:		
Purpose of Medication:		
Side Effects to be reported:		

_____ _____
Signature of Health Care Provider with Prescriptive Authority Date

_____ _____/_____
Print Name of Health Care Provider Phone & Fax Number

_____ _____
Signature of Child Care Health Consultant or School Nurse Date

Log 2 Week Medication Administration

School/Child Care:			
Child's Name:	Birthdate:		Classroom:
Medication:	Dosage:	Route:	Time to be given:
Start Date:	End Date:		Expiration Date:
Special Instructions:			
Health Care Provider Prescribing Medication:			Phone:
Parent Name:	Parent Work Phone:		Parent Cell Phone:

Time	Week of:					Week of:				
	Mon Date:	Tue Date:	Wed Date:	Thurs Date:	Fri Date:	Mon Date:	Tue Date:	Wed Date:	Thurs Date:	Fri Date:
AM:										
AM:										
PM:										
PM:										

Include time medication given and initials. If child absent, mark box with "A"; If medication not given, mark box "NG". Document reason not given in comments.

Date & Comments:

Staff Signatures	Initials

Intake and Count for All Medication

All controlled medications must be counted and verified by two medication trained staff members or by one staff member and parent (i.e. Ritalin, Dexedrine)

Date	Name of Medication and Dosage	Expiration Date	Amount Received	Parent Signature	Staff Initials