

Medication Administration in School or Child Care

The parent/guardian of _____ ask that school/child care staff give the
(Child's name)
following medication _____ at _____
(Name of medicine and dosage) (Time(s))

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

The Program agrees to administer medication prescribed by a licensed health care provider.

It is the parent/guardian's responsibility to furnish the medication.

The parent agrees to pick up expired or unused medication within one week of notification by staff.

Prescription medications must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, and 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.

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 nurse or school staff delegated to administer medication.

Parent/Legal Guardian's Name

Parent/Legal Guardian Signature

Date

Work Phone

Home Phone

Health Care Provider Authorization to Administer Medication in School or Child Care

Child's Name: _____

Birthdate: _____

Medication: _____

Dosage: _____ Route _____

To be given at the following time(s): _____

Special Instructions: _____

Purpose of medication: _____

Side effects that need to be reported: _____

Starting Date: _____

Ending Date: _____

Signature of Health Care Provider with Prescriptive Authority

License Number

Phone Number

Date

Please ask the pharmacist for a separate medicine bottle to keep at school/child care.

Thank you!

Medication Administration Log

Child's Name: _____ Date of Birth: _____ Rm.: _____

Medication: _____ Time(s): _____

Amount:: _____ Route: _____ Start Date for Medication: _____ End Date: _____

Special Instructions: _____

Name of Health Care Provider Prescribing Medication: _____ Phone: _____

Parent name: _____ Parent Work #: _____ Parent Home #: _____

	Week of:					Week of:				
	Mon Date	Tue Date	Wed Date	Thurs Date	Fri Date	Mon Date	Tue Date	Wed Date	Thu Date	Fri Date
A.M.										
P.M.										

Include Time Medication was Given and Initial

If the child is absent, mark box with an "A" ; If the medication was not given, mark box "NG" .
Document reason medication was not given in Comments.

Date & Comments:

Staff Signatures	Initials

Pills Received: (All controlled medications must be counted, e.g., Ritalin)