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 Medication & Dosage *Time(s)*

<u>Prescription medications</u>
medicine is to be given, dosage, route, date medicine is to be stopped, and licensed Health Care P
name. Pharmacy name and phone number must also be included on the label.

<u>Over the counter medication</u> . 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 docu rovider to share information about the administration of the medication with the school staff delegated to administer medication .

_____________________________ _________________________________ ____________

Parent/Legal Guardian Signature Date

____ ________________________________

Work Phone

Alternate Phone

****

Health Care Provider Authorization

		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:			
	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
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

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