

MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PARENT

Child's Name _____ Date of Birth ____/____/____
Program Name _____ Today's Date ____/____/____

To administer a prescription medication:

- The medication must be in it's original container, with a legible label from the pharmacy indicating the child's name, date, name of medicine, dosage, and time, number of days medication is to be given, and expiration date of medication, doctor's/nurse practitioners name, pharmacy name and telephone number
- Samples must be accompanied by a doctor's written prescription
- Medications are to be given only to the child indicated on the label (twins and siblings can not share.)
- A separate authorization is required for *each medication* and *each episode* of illness
- Label constitutes the physicians/nurse practitioner's order
- Parent/Guardian is to give as many doses as possible at home.

Medication: _____

Reason for medication: _____

Start date ____/____/____ End date ____/____/____

Dosage: _____ Times to be given at child care: _____ AM _____ PM

First dose was given at _____ AM/PM on date ____/____/____ (Medication Log needs to reflect Parent's first dose for each day.)

Route: by mouth, skin (location) _____, eye (R/L)

Possible side effects: _____

Special handling/storage Instructions _____ Refrigeration Y/N

Parent/Guardian Signature (required) _____

Physician/Nurse Practitioners Signature _____

Non-Prescription Medication:

- Parent is required to bring these medications from home.
- Medication must be in an original container, with child's name on the container.

Medication: _____ Health Care Provider _____

"For children under 2, list the name of the health care provider who recommended this medication."

Reason for medication: _____

Start date ____/____/____ End date ____/____/____

Dosage: _____ Times to be given at child care: _____ AM _____ PM

First dose was given at _____ AM/PM on date ____/____/____ (Medication Log needs to reflect Parent's first dose for each day.)

Route: by mouth, skin (location) _____, eye (R/L)

Possible side effects: _____

Special handling/storage Instructions _____ Refrigeration Y/N

Parent/Guardian Signature (required) _____

Unused medication: Returned to Parent Y/N Date ____/____/____ or Discarded appropriately Y/N Method _____

By: _____ Date ____/____/____

***Keep in the child's file when medication is finished.**