Child Care Medication Authorization Form

Name of Child:_____D.O.B.:_____Today's Date:_____

Name of Medication:_____

Reason for Medication:_____

Dose:_____Time/Frequency: _____

Route: ☐ Oral ☐ Topical ☐ Inhaled ☐ Injection ☐ Other

Date to Start:_____Date to stop:_____Expiration:_____

Additional Instructions/Comments: _____

_____

Known side effects:_____

_____

FOR PRESCRIPTION MEDICATION

Prescribing Health Care Provider:_____

Phone Number: _____

FOR OVER-THE-COUNTER MEDICATION

Amount of Medication Received:_____

Staff Member Signature:_____

I authorize (*child care center)* _____ personnel to administer the medication named above to my child in the manner as stated. I release any liability in relation to the administration of this medication. I also acknowledge that I, the parent/guardian, have given the first dose of this medication without any allergic or unexpected reactions.

Parent/guardian printed name: _____**Date Signed:** _____

Parent/guardian signature: _____

RETURN OR DISPOSAL OF MEDICATION

Return Date: _____ Parent Signature:_____

Disposal Date:_____ Staff Signature:_____

Witness to Disposal: _____

Child's Name:_____ Name of Medication:_____ Child's Primary Group:_____

ALWAYS review the written Parent/Guardian medication instructions and Health Care Provider's medical order (when necessary according to regulation) prior to EVERY administration. Instructions should be attached to this sheet.

7 Rights MUST be performed with EVERY dose! Right **child,** Right **medication**, Right **dose**, Right **route**, Right **time**, Right **reason**, Right **documentation**

Date Given	Time Given	Dose Given	Route Given	Time last dose was given by Guardian	Comments/Reactions	OVER-THE-COUNTER MEDICINE				Staff Signature	Quality Check
						Date Given	Time Given	Dose Given	Route Given		

When medication has been discontinued, it should be returned to the parents or disposed of properly.