Medication Administration Permission for 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 and 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, 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 Program 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) that are 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 nurse or school staff delegated to administer medication.

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

Work Phone **Home Phone**

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Health Care Provider Authorization

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**

Print Name of Health Care Provider **Phone** **Fax Number**

FOR SCHOOL USE ONLY: MEDICATION VERIFICATION CHECK LIST

DELEGATING RN SIGNATURE:: _____ **INITIALS:** _____

DELEGATED STAFF SIGNATURE:: _____ **INITIALS:** _____

DELEGATED STAFF SIGNATURE:: _____ **INITIALS:** _____

Initials		*Initials*		*Initials*	
	Parent Signature		*Med Exp Date:*		*Email / Phone/ fax Nurse*
	Health Provider Signature		*Completed Log*		*Notify Staff*
	Checked 5 Rights				
	Count and verify meds				