Authorization to Give Medication at School From Provider & Parents

Name of Center ____
Today's Date ____
Child's Name ______________________________ DOB ____________________
Name of Medication ____
Dose ______________________ Route ______________ Time ____________
Start Date ______________________ End Date ______________________
Purpose of Medication ____
Adverse or Side Effects ____
Special Instructions ____
Provider's Printed Name ____
Provider's Signature ____
Provider's Phone # ____

Parent/Guardian Authorization to Give Medication

______________________________ Childcare Center has my permission to administer
(Name of center)

____ to my child
(Name of medication)

______________________________ starting on ______________________
(Child's name) (Date)

and ending on ______________________ as prescribed by the provider.
(Date)

______________________________________ ______________________
(Signature of parent) (Date)

All medication must be in the original pharmacy labeled container including the following information : Name of child, medicine, provider, and date, dose, time, route.

DATE	TIME	MEDS/DOSE	GIVEN BY	REASON,IF NOT GIVEN

Starting Medication Count__________________ # of Pills______________ Date ______________

Date	Count	Init.	Date	Count	Init.	Date	Count	Init.	Date	Count	Init.

When medication administration is completed, return this form to office for child's permanent file.