Bright Horizons FAMILY SOLUTIONS®

FORM

Medication Authorization Form

MEDICATION TYPE: ❒ **PRESCRIPTION** ❒ **NON-PRESCRIPTION**

Child's Name: _____ **Date of Birth:** _____

All medication must be provided in the original container, labeled with the child's full name. Where applicable, the implement for proper measurement must be provided and labeled with the child's full name. If not provided, medication cannot be administered. Non-prescription medications must be designated for use for children on the label.

I have read the *Medication Administration Policy* in the Bright Horizons Family Guide and I hereby authorize Bright Horizons agents to administer the following medication to my child.

Prescription Medications: must have a current pharmacist's label that includes the child's full name, dosage, current date, times to be administered, and the name and telephone number of the physician.

Non-prescription Medication: with written authorization from parent/guardian can be administered according to the manufacturer's instructions for **up to five consecutive days in a 30 day period**. Written authorization from the child's medical provider is required for any deviation in manufacturer's instructions.

Standing Orders: with written authorization from the child's medical provider may be administered according to physician's instructions for **a period not to exceed six months**. Authorization must list the reason, dosage, instructions, start date and end date.

Medications for Chronic Illnesses: require a health care plan completed by the child's medical provider for a period not to exceed one year. Must include complete medication administration information, otherwise a completed Medication Authorization Form signed by medical provider is required (See Prescription and Non-prescription medication above for details).

Homeopathic/Herbal/Homemade Medications: may be administered for up to **1 year** with physician authorization.

Note: Products containing Benzocaine, the main ingredient in over-the-counter (OTC) gels and liquids applied to the gums or mouth to reduce pain, may only be applied with authorization from the child's medical provider.

On behalf of myself, my family and my minor child, I hereby release and agree to defend, hold harmless, and indemnify Bright Horizons Family Solutions LLC., its subsidiaries, affiliates, and employees, from any and all claims of injury or damage (including personal injury) as a result of any and all acts performed under this authority and according to the instructions below.

Medication: _____ Administration Route: _____

Reason for Medication: _____ Refrigeration Required? ❑Yes ❑No

Dosage: _____

Times of Administration: _____ _____ _____ _____

Start Date: _____ End Date: _____

Side Effects: _____

Parent/Guardian Signature: _____ Date: _____

Physician's Name: _____ Physician's License Number: _____

Physician's Signature: _____ Date: _____