MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PARENT

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

To administer a PRESCRIPTION MEDICATION:

- The medication must be in its original container, with a legible label from the pharmacy indicating the child's first and last name, date, name of medication, dosage, and time, number of days medication is to be given, and expiration date of medication, doctor's / nurse practitioner's 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/siblings cannot 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.

To administer a NON-PRESCRIPTION MEDICATION:

- Parent is required to bring these medications from home
- Medication must be in the original container, with child's first and last name on the container.
- Ensure age of child and dosage is represented on the label or provide physician's written authorization of dosage amount.
- Non-prescription medication includes but is not limited to: sunscreen, insect repellent, diaper ointment, teething gel (with a physician's note for children under two years), etc.

AUTHORIZATION

The medication listed below is: ☐ Prescription ☐ Non-Prescription
Medication: _____ Expiration Date: _____
For children under 2, list the name of the health care provider who recommended this medication.
Health Care Provider: _____
Reason for giving: _____
Start Date: _____ End Date: _____ Dosage: _____
Times to be given at child care: _____ AM _____ PM
Last dosage was given at _____ AM / PM on the following date _____
Route: (oral, topical and location, eye drops – which eye) _____
Possible side effects: _____
Special handling / storage instructions: _____ Refrigeration? ☐ Yes ☐ No
Physician / Nurse Practitioners Signature (optional): _____

This authorization is valid for one year from Parent Signature date.

Parent request for unused medication to be: ☐ Returned to Parent ☐ Discarded Appropriately

_____ _____
Parent / Guardian Signature Date

KEEP IN CHILD'S FILE WHEN MEDICATION IS FINISHED

MEDICATION ADMINISTRATION LOG

TO BE COMPLETED BY NEW CREATIONS STAFF

To ensure the proper handling, administration and storing of medication for each child in care, medication may only be given by the Director, Assistant Director or the Health and Safety Coordinator at the center and must be stored in a locked medicine cabinet in the Director's office. The below log must be completely filled in each time medication is provided.

The Medication Authorization Form must be filled out prior, to give the center permission to give the medication.

This log is attached to the Medication Authorization Form which includes the doctor's prescription information. Directions for this medication are provided by parent on the other side of this paper. Follow them carefully and record when medication was administered. Keep this record in the classroom binder.

Name (First & Last): _____ Date of Birth: _____

Classroom: _____

Illness: _____

Medication Name: _____ Expiration Date: _____

Amount to administer and frequency: _____

Duration of the prescription: _____ Finished on this date: _____

Date	Time	Medication	Route (ie: Oral, topical, eye drops)	Amount	Name (First & Last) AND Initials

Staff must **wash hands** before and after administering medication and follow the **Six Rights to Administering Medication** when ever any medication is given.

- **Right Child**
- **Right Medication**
- **Right Time**
- **Right Dose**
- **Right Route**
- **Right Child's Documentation Log Sheet**

Attach current Parent / Health Care Provider "signed" Medication Authorization Form
Be sure to note "absence" or "missed dose" in date section when appropriate.

Name (First & Last): ______________________ Date of Birth: __________

Classroom: ____

Illness: ____

Medication Name: ______________________ Expiration Date: __________

Amount to administer and frequency: ______________________________

Duration of the prescription: ______________ Finished on this date: __________

Date	Time	Medication	Route (ie: Oral, topical, eye drops)	Amount	Name (First & Last) AND Initials