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.