

## **Prescribed Medication Authorization Form**

NOTE: Medication shall not be administered to any child in child care if not prescribed or recommended by a licensed health care provider (physician, dentist, nurse practitioner).

Child's Name	Medication Name	
Parents Emergency Numbers	,,	_
Date Medication Filled	Medication Expiration Date	_
Physician's Name	Address	-
Office Number	Emergency Number	_
Pharmacist's Name	Address	_
Name of Drug Store	Office Number_	_
II "PRIN" or "as needed" a clear	n is to be Administeredexplanation is required	_
Route and Dosage of Medication	n	-
Directions for Storage		_
Directions for Disposal (Please of Send Home	check one of the following)  Destroy and Dispose of in Appropriate Container	
instructions. Medication mocontainer. Please attach w	ement of desired effects, side effects and speci ust be brought into the center by a parent and ma- ritten instructions received from physician. In for mentioned, please sign below.	ust be kept in the original
Parent Signature	Date	

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	Jse Only					
1) Staff	f Member A	Administrati	ng Medication:			
D.	<b></b>	D		Full Sign		
Date	Time	Dosage	Safety Check Complete	Tuitial	45-minute Observation	Initial
				muai		iniuai
2) Stan	i Member A	Aaministrati	ng Medication:	Full Sign	4	
Data	Time	Dosage	Safety Check Complete	Full Sigi	18 minute Observation	
Date	1 IIIIC	Dosage	Safety Check Complete	 Initial		Initial
3) Stoff	f Mombor	A dministrati	ng Medication:	IIIIII		IIIItiai
3) Stail	i Michibel A	Aummisti ati	ing Medication.	Full Sign	natura	
Date	Time	Dosage	Safety Check Complete			
Datc	I IIIIC	Dosage	Salety Check Complete	 Initial		Initial
1) Staff	f Mambar	A dministrati	ng Medication:			IIIItiai
T) Stan	i wichibei z	Aummisti ati	ing Medication.	Full Sign	nature	
Date	Time	Dosage	Safety Check Complete			
	1 iiii		salety check complete	 Initial		Initial
5) Staff	f Member	Administrati	ng Medication:			
J) Stan	i wiember 2	i kanningti ati	ing ivicultation:	Full Sign	nature	
Date	Time	Dosage	Safety Check Complete			
			sures, chesh compress	Initial		Initial
6) Staff	f Member	Administrati	ng Medication:			
o) star		141111111111111111111111111111111111111		Full Sign	nature	
Date	Time	Dosage	Safety Check Complete		45-minute Observation	
				Initial		Initial
7) Staff	f Member A	Administrati	ng Medication:			
,				Full Sign	nature	
Date	Time	Dosage	Safety Check Complete			
				Initial	_	Initial
8) Staff	f Member A	Administrati	ng Medication:			
,				Full Sign	nature	
Date	Time	Dosage	Safety Check Complete	>	45-minute Observation	
				Initial		Initial
9) Staff	f Member A	Administrati	ng Medication:			
,				Full Sign	nature	
Date	Time	Dosage	Safety Check Complete	·	45-minute Observation	
				Initial		Initial
10) Sta	ff Member	Administra	ting Medication:			
				Full Sign		_
Date	Time	Dosage	Safety Check Complete		45-minute Observation _	
				Initial		Initial



## **Over the Counter Medication Authorization Form**

NOTE: Medication shall not be administered to any child in childcare if not prescribed or recommended by a licensed health care provider (physician, dentist, nurse practitioner).

Child's Name	Medication Name
Parents Emergency Numbers	
Date Medication Brought to Center	Medication Expiration Date
Physician's Name	Address
Office Number	Emergency Number
If "PRN" or "as needed" a clear explanation	Administeredon is required
Directions for Storage	
Directions for Disposal (Please check one	of the following)
Send Home	Destroy and Dispose of in Appropriate Container
Please attach a written statement of desired	d effects, side effects and specific instructions. Medication must be
brought into the center by a parent and mu	ast be kept in the original container. Medications with instructions such as
"as needed" or "PRN" shall be accompani	ed by a clear written explanation defining when the medication is to be
administered. Please attach written instruc	tions received from physician. In order for this center to administer the
medication for mentioned, please sign belo	ow.
Doront Signature	Data

Office Use Only 1) Staff Member Administrating Medication: Full Signature Date Time Safety Check Complete 45-minute Observation Initial 2) Staff Member Administrating Medication: \_\_\_\_ Full Signature Date\_\_\_\_\_ Time \_\_\_\_ Safety Check Complete \_ 45-minute Observation 3) Staff Member Administrating Medication: Full Signature Date\_\_\_\_\_ Time \_\_\_\_ Safety Check Complete \_\_\_\_\_ 45-minute Observation Initial 4) Staff Member Administrating Medication: Full Signature Date\_\_\_\_\_ Time \_\_\_\_ Safety Check Complete \_\_\_\_\_ 45-minute Observation \_ Initial Initial 5) Staff Member Administrating Medication: Full Signature Date\_\_\_\_\_ Time \_\_\_\_ Safety Check Complete \_\_\_\_\_ 45-minute Observation Initial 6) Staff Member Administrating Medication: Full Signature Date \_\_\_\_\_ Time \_\_\_\_ Safety Check Complete \_\_\_\_\_ 45-minute Observation \_\_\_\_\_ Initial 7) Staff Member Administrating Medication: Full Signature Date\_\_\_\_\_ Time \_\_\_\_ Safety Check Complete \_\_\_ 45-minute Observation Initial 8) Staff Member Administrating Medication: Full Signature Date\_\_\_\_\_ Time \_\_\_\_ Safety Check Complete 45-minute Observation Initial 9) Staff Member Administrating Medication: \_\_\_ Full Signature Date\_\_\_\_\_ Time \_\_\_\_ Safety Check Complete \_\_\_\_\_ 45-minute Observation \_\_ Initial 10) Staff Member Administrating Medication: Full Signature Date\_\_\_\_\_ Time \_\_\_\_ Safety Check Complete \_\_\_\_\_ 45-minute Observation Initial Initial



## Physician Authorization/Instructions

Child's Name	Date of Birth	Child Care Center
To be completed by Physician  1. Diagnosis:	or Dentist:	
2. Medication: A.	В.	•
C	D.	
3. Instructions and Method of Ad	ministration:	
4. Duration of Medication:		
5. Anticipated Reactions and/or si	ide effects.	
Date	P	Physician's Signature
**************************************		**************************************
		Riverside Academy to give the above I release have been observed.
Signature of Parent or	 Guardian	Witness