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_____

Frequency and Time Medication is to be Administered_____
If "PRN" or "as needed" a clear explanation is required _____
_____
_____

Route and Dosage of Medication _____

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 effects, side effects and specific instructions. Medication must be brought into the center by a parent and must be kept in the original container. Please attach written instructions received from physician. In order for this center to administer the medication for mentioned, please sign below.

_____ _____

Parent Signature **Date**

****

Office Use Only

1) Staff Member Administrating Medication: _____
Full Signature

Date_____ Time _____ Dosage _____ Safety Check Complete _____ 45-minute Observation _____
Initial Initial

2) Staff Member Administrating Medication: _____
Full Signature

Date_____ Time _____ Dosage_____ Safety Check Complete _____ 45-minute Observation _____
Initial Initial

3) Staff Member Administrating Medication: _____
Full Signature

Date_____ Time _____ Dosage_____ Safety Check Complete _____ 45-minute Observation _____
Initial Initial

4) Staff Member Administrating Medication: _____
Full Signature

Date_____ Time _____ Dosage_____ Safety Check Complete _____ 45-minute Observation _____
Initial Initial

5) Staff Member Administrating Medication: _____
Full Signature

Date_____ Time _____ Dosage_____ Safety Check Complete _____ 45-minute Observation _____
Initial Initial

6) Staff Member Administrating Medication: _____
Full Signature

Date_____ Time _____ Dosage_____ Safety Check Complete _____ 45-minute Observation _____
Initial Initial

7) Staff Member Administrating Medication: _____
Full Signature

Date_____ Time _____ Dosage_____ Safety Check Complete _____ 45-minute Observation _____
Initial Initial

8) Staff Member Administrating Medication: _____
Full Signature

Date_____ Time _____ Dosage_____ Safety Check Complete _____ 45-minute Observation _____
Initial Initial

9) Staff Member Administrating Medication: _____
Full Signature

Date_____ Time _____ Dosage_____ Safety Check Complete _____ 45-minute Observation _____
Initial Initial

10) Staff Member Administrating Medication: _____
Full Signature

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_____

Frequency and Time Medication is to be Administered_____
If "PRN" or "as needed" a clear explanation is required _____
_____
_____

Route and Dosage of Medication _____

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 effects, side effects and specific instructions. Medication must be brought into the center by a parent and must be kept in the original container. Medications with instructions such as "as needed" or "PRN" shall be accompanied by a clear written explanation defining when the medication is to be administered. Please attach written instructions received from physician. In order for this center to administer the medication for mentioned, please sign below.

Parent Signature_____**Date**_____

****

Office Use Only

1) Staff Member Administrating Medication: _____
Full Signature

Date_____ Time _____ Safety Check Complete _____ 45-minute Observation _____
Initial Initial

2) Staff Member Administrating Medication: _____
Full Signature

Date_____ Time _____ Safety Check Complete _____ 45-minute Observation _____
Initial Initial

3) Staff Member Administrating Medication: _____
Full Signature

Date_____ Time _____ Safety Check Complete _____ 45-minute Observation _____
Initial 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 Initial

6) Staff Member Administrating Medication: _____
Full Signature

Date_____ Time _____ Safety Check Complete _____ 45-minute Observation _____
Initial Initial

7) Staff Member Administrating Medication: _____
Full Signature

Date_____ Time _____ Safety Check Complete _____ 45-minute Observation _____
Initial Initial

8) Staff Member Administrating Medication: _____
Full Signature

Date_____ Time _____ Safety Check Complete _____ 45-minute Observation _____
Initial Initial

9) Staff Member Administrating Medication: _____
Full Signature

Date_____ Time _____ Safety Check Complete _____ 45-minute Observation _____
Initial 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 or Dentist:

1. **Diagnosis:** _____

2. **Medication: A.** _____ **B.** _____

   C. _____ **D.** _____

3. **Instructions and Method of Administration:**

_____
_____
_____

4. **Duration of Medication:** _____

5. **Anticipated Reactions and/or side effects.**

_____
_____
_____

Date	Physician's Signature
_____	_____

****

Special Instructions (If any): _____.

I the undersigned give permission for the medication-trained staff of **Riverside Academy** to give the above medication as prescribed and described to my child, _____. I release **Riverside Academy** of all liability provided the above instructions have been observed.

Signature of Parent or Guardian	Witness
_____	_____