Parent/ Guardian Medication Authorization Form

Prescribed and over the counter medication

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

Child's Name: ____

Medication Name/Strength: ____

Route and Dosage of Medication: ____

____

Frequency and Time for medication to be administered: ___________________________

____

Duration of administering the medication: ______________________________________

Direction for storage: ____

A written statement of the desired effects, side effects and specific instructions (Standardized print-out from the pharmacist includes most of this information and is acceptable to use)

____

____

___ Is the medication in its original container?

Physician's name, business address, office telephone number and emergency numbers.

____

____

Pharmacist's Name, business address and phone number: ____________________________

____

Parent/ Guardian Signature: ____

Print name: ____

Date: _____________________________________

****If all information is not filled in completely, medication will not be administered.**

For Childcare Staff to Complete

Administration Documentation

Administer medication only if you can answer yes to all the questions:

Is the name of the child on the container? ____Yes ____No

Is the medication in the original container? ____Yes ____No

Is the original prescription label readable on the container? ____Yes ____No

Is the permission forms completed? ____Yes ____No

Is the medication label current (not expired)? ____Yes ____No

Signature of the childcare provider:____

Date Given	Time Given	Dosage Given	Comments	Signature of Person Administering Medication

For long term mediation administration of the same medication to child:

Signature of parent____ **Date** _____________

Signature of parent____ **Date** _____________

Signature of parent____ **Date** _____________

Signature of parent____ **Date** _____________

Signature of parent____ **Date** _____________

Parent/ Guardian Medication Authorization Form

Prescribed, over the counter and emergency medication as needed

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

Child's Name: ____

Medication Name/Strength: ____

Dosage of Medication: ____

____

When medication is to be administered (Signs to look for, special instructions / circumstances):

____

How medication is to be administered: oral topical other ______________________

Direction for storage: ____

A written statement of the desired effects, side effects and specific instructions (Standardized print-out from the pharmacist includes most of this information and is acceptable to use)

____

____

___ Is the medication in its original container?

Physician's name, business address, office telephone number and emergency numbers.

____

____

Pharmacist's Name, business address and phone number: ___________________________

____

Parent/ Guardian Signature: ____

Print name:____

Date: _____________________________________

****If all information is not filled in completely, medication will not be administered.**

For Childcare Staff to Complete

Administration Documentation

Administer medication only if you can answer yes to all the questions:

Is the name of the child on the container? ____Yes ____No

Is the medication in the original container? ____Yes ____No

Is the original prescription label readable on the container? ____Yes ____No

Is the permission forms completed? ____Yes ____No

Is the medication label current (not expired)? ____Yes ____No

Signature of the childcare provider:____

Date Given	Time Given	Dosage Given	Comments	Signature of Person Administering Medication

For long term mediation administration of the same medication to child:

Signature of parent____ **Date** _____________

Signature of parent____ **Date** _____________

Signature of parent____ **Date** _____________

Signature of parent____ **Date** _____________

****Shall be updated by parents as changes occur or at least every 3 months****

Silliman Institute Day Care

Director Jan Aguillard **(225)683-5383 Ex. 501**

Po Box 946 **Fax (225)683- 6728**

Clinton, LA 70722

Physician, Dentist, or Nurse Practitioner

Medication Authorization Form

Please Print

I ____ (circle) prescribe / recommend that

(Child's name)____

Is be administered (medication name)____

____

Dosage/Route____

____

Time and Frequency the medication is to be Administered

____

____

If "PRN" or "As Needed" a clear explanation is required

____

____

____

Date the medication was prescribed/recommended_____________________________________

Signature: ____ Date: ______________________

****This form will need to be returned to the Silliman Institute Day Care with all information filled in and readable before the staff can administer the medication.**