Medication Authorization

Attach picture of child here. Make copies for other forms.

Dear Parents: Please make sure you have reviewed and signed our medication policy.

Child's Name: *First* *Last*	Weight:	Date of birth:

MEDICATION INFORMATION

Medication:	When to give:
Route: *(e.g., by mouth)*	Dose:
Reason for medication:	Medication expiration date:
	Allergies:
Start date: Stop date:	Storage Requirements: Refrigeration: ☐ YES ☐ NO
Special Instructions: *(e.g., take with food)*	Possible side effects:
Notes:	

PARENT PERMISSION TO GIVE MEDICATION

- I hereby give permission for the child care staff to administer medication as prescribed above.
- I also give permission for the caregiver/teacher to contact the prescribing health professional about the administration of this medication.
- I have administered at least one dose of medication to my child without adverse effects, except one-time emergency medications *(e.g. Epi Pen)*.

Parent/Guardian Signature: Phone:

Print Name: Alternate Phone:

MEDICAL PROVIDER'S INFORMATION

Name: Phone:

Signature:

Prescription label has medical provider's complete information and name ☐ YES ☐ NO

OFFICE USE ONLY

Storage location: Locked ☐ YES ☐ NO	Name of staff receiving medication:
Individual Health Care Plan up-to-date? ☐ YES ☐ NO ☐ Not required for this medication	Amount of medicine received:
Emergency Information up-to-date? ☐ YES ☐ NO	Date:

This form developed by Snohomish Health District
Child Care Health Outreach Program
3020 Rucker Avenue, Suite 208 ■ Everett, WA 98201-3900 ■ fax: 425.339.8706 ■ tel: 425.339.5278

Attach picture of child here.

Medication Record

Child's Name: *First* *Last*	**Medication:**

Compare Medication Authorization to container label *at each administration.*
Check 5 Rights: ✓ CHILD ✓ MEDICATION ✓ DOSE ✓ ROUTE ✓ TIME

DATE	TIME	MEDICATION	DOSAGE	NOTES/CONCERNS	STAFF

Incident/Error Form Completed ☐ YES ☐ NO *(see child's file)*

TO BE COMPLETED BY CHILD CARE PROVIDER:

I am trained to give this medication and understand the child care medication policy and procedures.

Print Name_____ **Print Name**_____

_____ **(_____)** _____ **(_____)**
Signature **(initials)** **Signature** **(initials)**

Medication Returned: Date:

Parent/guardian Signature: Staff signature:

If you can't return the medication, contact Take Back Your Meds at 1-800-732-9253 for proper disposal and location.
Do not put in trash or toilet.

Disposal Location: Signature: Date:

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