



PUDDLE JUMPERS CEC
 Georgia Department of Early Care and Learning
AUTHORIZATION FOR MEDICATION

MEDICATION MUST BE IN ITS ORIGINAL CONTAINER WITH THE CHILD'S NAME.

Child's Name: _____ Date of Birth: _____

Child's Classroom: _____

Name of Medication: _____

Prescription Number: _____

Does the medication require refrigeration? _____

Last time child was given medication _____

Medication WILL BE dispensed at 10:00am & 2:00pm ONLY:
 10:00am _____ OR 2:00pm _____ BOTH: _____

(Medication will not be given on an "As Needed" basis, specifics must be provided)

Amount of Medication to be given: _____

Dates to be given: _____

(Not to exceed two weeks without a physician's statement)

 PARENT'S SIGNATURE DATE

FOR CENTER USE (Reminder: document the reasons why medications are not given as parent requested i.e., child absent, medication not sent, child sleeping etc...)

DATE TIME GIVEN AMOUNT ANY ADVERSE REACTIONS ADMINISTERED BY

1.	_____	_____	_____	_____	_____ / _____
2.	_____	_____	_____	_____	_____ / _____
3.	_____	_____	_____	_____	_____ / _____
4.	_____	_____	_____	_____	_____ / _____
5.	_____	_____	_____	_____	_____ / _____
6.	_____	_____	_____	_____	_____ / _____
7.	_____	_____	_____	_____	_____ / _____
8.	_____	_____	_____	_____	_____ / _____
9.	_____	_____	_____	_____	_____ / _____
10.	_____	_____	_____	_____	_____ / _____
11.	_____	_____	_____	_____	_____ / _____
12.	_____	_____	_____	_____	_____ / _____
13.	_____	_____	_____	_____	_____ / _____
14.	_____	_____	_____	_____	_____ / _____

Attention to Person Requesting Medication Be Dispensed:
Form must be completed in it's entirety before the center can dispense any medication