

# *Santa Rosa Rise and Shine Child Care Center*

## PARENT'S PERMISSION TO ADMINISTER MEDICATION

(REQUIRED FOR ALL MEDICATIONS)

Classroom: \_\_\_\_\_

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

### Medication Information

Start Date: \_\_\_\_\_

End Date: \_\_\_\_\_

Name of Prescribed Medication: \_\_\_\_\_

Method of Use (only oral, inhaled or topical medications will be given at the Children's Center):

Oral

Inhaled

Topical

Dosage Prescribed: \_\_\_\_\_

Number of Times Given per Day **or** Time of Day to be Given: \_\_\_\_\_

Illness or Condition Treating: \_\_\_\_\_

Medication Storage Instructions: \_\_\_\_\_

Possible Side Effects: \_\_\_\_\_

### Physician's Information

Name of Prescribing Physician: \_\_\_\_\_

Prescribing Physician's Phone #: \_\_\_\_\_

### Parent Instructions

In case of an unexpected reaction to the medication do the following: \_\_\_\_\_

I/We the undersigned am/are the parent/legal guardian with legal custody of the above listed child. I/We hereby authorize *Santa Rosa Rise and Shine Child Care Center* and any staff member to administer the above listed medication. I/ We agree to inform *Santa Rosa Rise and Shine Child Care Center* of any changes in the above instructions in which case a new Permission to Administer Medication form will be completed. This form will remain in effect until the above listed end date unless instructions are given in writing to the contrary.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_