Natural Start PRESCHOOL

MEDICATION AUTHORIZATION FORM

This form is valid for no longer than twelve (12) months. One form must be used for <u>each</u> medication.

<u>Box 1</u>:The following section must be completed by the parent/guardian.

Check all that apply:

- ☐ Prescription medication
- ☐ Nonprescription medication
- ☐ Refrigeration required
- ☐ Topical product or lotion
- ☐ Food supplement
- ☐ Modified diet

Complete all of the following information:

Name of Child:_____ Date of Birth:_____ Weight:_____

Name of Medication:_____ Exact Dosage:_____

To be administered at the following times:_____

For the following period of time:_____

Signature of Parent/Guardian:_____ Date:_____

<u>Box 2</u>: The following section must be completed by a licensed physician, a licensed dentist, or an advance practice nurse when:

1. A physician's instruction is needed for a nonprescription medication (e.g. child is underage or underweight per the label instructions); or
2. It is a sample medication without a prescription label; or
3. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period or is a topical product or lotion that is being used for a skin ailment and is to be applied longer than fourteen consecutive days; or
4. The child is on a modified diet (an entire food group is eliminated) or food supplement; or
5. The medication contains codeine or aspirin.

_____ is under my care and should receive _____
Name of child — Name of medication, vitamin, diet

as follows:_____.
Include dosage and instructions

Possible side effects to watch for are:_____.

Expiration date:_____ (May not exceed 12 months from the date of this request for medications or food supplements)

_____ _____ _____
Signature of physician, dentist, or advance practice nurse — Date — Phone number

<u>Box 3</u>: The section below must be completed by Natural Start Preschool staff and each administration of medication must be documented. All dosages must be recorded below.

_____ was given _____ as follows:
Name of child Name of medication, vitamin, or diet

Date and Time of Dosage	Dosage Amount	Signature of Staff Administering Medication