DPHHS-QAD/CCL-121
(Revision 10-06)

MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PARENT

Child's Name_____Date of Birth_____/____/___
Program Name_____Today's Date_____/____/___

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To administer a prescription medication:

- The medication must be in it's original container, with a legible label from the pharmacy indicating the child's name, date, name of medicine, dosage, and time, number of days medication is to be given, and expiration date of medication, doctor's/nurse practitioners name, pharmacy name and telephone number
- Samples must be accompanied by a doctor's written prescription
- Medications are to be given only to the child indicated on the label (twins and siblings can not share.)
- A separate authorization is required for *each medication* and *each episode* of illness
- Label constitutes the physicians/nurse practitioner's order
- Parent/Guardian is to give as many doses as possible at home.

Medication:_____
Reason for medication:_____
Start date_____/____/___ End date____/____/____
Dosage:_____ Times to be given at child care:_____AM_____PM

First dose was given at_____AM/PM on date____/____/____ (Medication Log needs to reflect Parent's first dose for each day.)
Route: by mouth, skin (location)_____, eye (R/L)

Possible side effects:_____

Special handling/storage Instructions_____Refrigeration Y/N

Parent/Guardian Signature (required)_____
Physician/Nurse Practitioners Signature_____

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Non-Prescription Medication:

- Parent is required to bring these medications from home.
- Medication must be in an original container, with child's name on the container.

Medication:_____Health Care Provider_____
"For children under 2, list the name of the health care provider who recommended this medication."

Reason for medication:_____
Start date_____/____/___ End date____/____/____
Dosage:_____ Times to be given at child care:_____AM_____PM

First dose was given at_____AM/PM on date____/____/____ (Medication Log needs to reflect Parent's first dose for each day.)
Route: by mouth, skin (location)_____, eye (R/L)
Possible side effects:_____
Special handling/storage Instructions_____Refrigeration Y/N

Parent/Guardian Signature (required)_____

Unused medication: Returned to Parent Y/N Date ____/____/____ or Discarded appropriately Y/N Method _____

By: _____ Date _____/_____/_____

***Keep in the child's file when medication is finished.**