Great Escape Early Learning Center

Medication Administration

The parent/guardian of ________________________________ ask that school/child care staff give the
(Child's name)

following medication ______________________________________;at ______________
(Name of medicine and dosage) {Time(s))

to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

The Program agrees to administer medication prescribed by a licensed health **care provider.**
It is the parent/guardian's responsibility to furnish the medication.
The parent agrees to pick up **expired or unused medication within one week of notification by staff.**

Prescription medications must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, and date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.

Over the counter medication must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the nurse or school staff delegated to administer medication.

___________________________ ___________________________________ ____________
Parent/Legal Guardian's Name Parent/Legal Guardian Signature Date

______________________________________ ___________________________________
Work Phone Home Phone

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Health Care Provider Authorization to Administer Medication in School or Child Care

Child's Name:.____ Birthdate:_______________

Medication: ____

Dosage: _ _ _ _ _ _ _ _ _ _ _ _ _ Route _ _ _ _ _

To be given at the following time(s): ____

Special Instructions:____

Purpose of medication: ____

Side effects that need to be reported:____

Starting Date:_____________________ **Ending Date:**__________________

____ _____________________________
Signature of Health Care Provider with Prescriptive Authority **License Number**

____ _____________________________
Phone Number **Date**

Please ask the pharmacist for a separate medicine bottle to keep at school/child care.

Thank you!