

**Medication Administration in School or Child Care**  
**Both top and bottom portions must be completed in order to be accepted.**

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, 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  
 \*\*\*\*\*

**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!*