

Child Care Medication Authorization Form

Name of Child: _____ D.O.B.: _____ Today's Date: _____

Name of Medication: _____

Reason for Medication: _____

Dose: _____ Time/Frequency: _____

Route: Oral Topical Inhaled Injection Other

Date to Start: _____ Date to stop: _____ Expiration: _____

Additional Instructions/Comments: _____

Known side effects: _____

FOR PRESCRIPTION MEDICATION

Prescribing Health Care Provider: _____

Phone Number: _____

FOR CONTROLLED SUBSTANCES

Amount of Medication Received: _____

Staff Member Signature: _____

Staff Member Signature: _____

I authorize (*child care center*) _____ personnel to administer the medication named above to my child in the manner as stated. I release any liability in relation to the administration of this medication. I also acknowledge that I, the parent/guardian, have given the first dose of this medication without any allergic or unexpected reactions.

Parent/guardian printed name: _____ **Date Signed:** _____

Parent/guardian signature: _____

RETURN OR DISPOSAL OF MEDICATION

Return Date: _____ Parent Signature: _____

Disposal Date: _____ Staff Signature: _____

Witness to Disposal: _____

