MEDICATION ADMINSTRATION RECORD

(A separate authorization is required for each medication) also known as "Medication Permission Form"

I, ______________________ (Parent), give permission for ______________________ (Child Care Center)

to give ______________________ (Full First & Last Name) the following medication:

Medication: ______________________

Amount/Dose: ______________________

Time of Dose/Frequency: ______________________

Route of administration: ☐Oral ☐Rectal ☐Topical ☐Inhaled ☐Eye/Nose/Ear ☐Other: __________

Start Date: __________ End Date: __________

Reason for Medication: ______________________

Possible Side Effects: ______________________

Physician Signature (for Over the Counter Medication): ______________________ **Date:** __________

Parents Signature: ______________________ **Date:** __________

For Staff to Complete

Give medicine **only** if you can answer **yes** to all questions below.

Question	Yes	No
Is the Medication Administration Record complete?	☐ Yes	☐ No
Is the medication in a child-resistant container?	☐ Yes	☐ No
Is the original prescription label on the medication container	☐ Yes	☐ No
Is the child's first and last name on the container?	☐ Yes	☐ No
Is the date on prescription current? (Within the month for antibiotics and within the expiration date for medications which are so labeled; within the year otherwise?)	☐ Yes	☐ No

	Monday		Tuesday		Wednesday		Thursday		Friday	
Dose										
Date										
Time										
Initials										
Comments										

	Monday		Tuesday		Wednesday		Thursday		Friday	
Dose										
Date										
Time										
Initials										
Comments										

Teacher's name (signature/initials)	Teacher's name (signature/initials)

Unused medication: Date returned to parents ______________________

Place this form in child's file when medication is finished.