Medication Administration in School or Child Care

| The parent/guardian of | | ask that | school/child care staff |
|--|---|-------------------|-----------------------------|
| | (Child's name) | | |
| Give the following medication | /Nome of modicine | and dosocol | at |
| | (Name of medicine a | | ording to the Health |
| (Time(s)) | | ,, a | ser annig ser anne riceanni |
| Care Provider's signed instructions | on the lower part of this forr inister medication prescribe | | مراند مراد ما المامد |
| 0 0 | esponsibility to furnish the n | • | ieaith care provider. |
| | expired or unused medicat | | week of notification by |
| Prescription medications must com | e in a container labeled with | : child's name, n | ame of medicine, time |
| medicine is to be given, dosage, and | | | health care provider's |
| name. Pharmacy name and phone no | | | |
| Over the counter medication must be care provider authorization, and medication. | | - | atch the signed health |
| By signing this document, I give per | | ~ | o share information |
| about the administration of this me | _ | - | |
| medication. | | | |
| Parent/Legal Guardian's Name | Parent/Legal Guardian | Signature | Date |
| Work Phone | Home | Phone | |
| Health Care Provider Author | orization to Administer Med | ication in Schoo | l or Child Care |
| Child's Name: | | Birthdate: | |
| Medication: | | | |
| B | Route: | | |
| To be given at the following time(s) | <u>:</u> | | |
| Special Instructions: | | | |
| Purpose of medication: | | | |
| Side effects that need to be reporte | d: | | |
| Starting Date: | Ending Date: | | |
| Signature of Health Care Provider w | rith Prescriptive Authority | License Numb | per |
| Phone Number | | Date | |

 $\underline{\textit{Please ask the pharmacist for a separate medicine bottle to keep at school/child care.}}$

Thank you!