## Child Care Medication Authorization Form

Name of Child:	D.O.B.:	Today's Date:	
Name of Medication:			
Reason for Medication:			
Dose:Time/Fred	quency:		
Route: Oral Topical	Inhaled	☐ Injection ☐	Other
Date to Start:Date			
Known side effects:			
FOR PRESCI	RIPTION MEDICAT	TION	
Prescribing Health Care Provider:			
Phone Number:			
FOR CONT	ROLLED SUBSTAN	CES	
Amount of Medication Received:			
Staff Member Signature:			
Staff Member Signature:			_
I authorize ( <i>child care center</i> )	F	personnel to administer the	e medication
named above to my child in the manner as of this medication. I also acknowledge the medication without any allergic or unexpe	at I, the parent/gu	•	
Parent/guardian printed name:		Date Signed:	
Parent/guardian signature:			
RETURN OR DI	SPOSAL OF MEDIC	CATION	
Return Date:	Parent Signature:		
Disposal Date:	Staff Signature:		
Witness to Disposal:			

Child's Name:	Name of Medication:	Child's Primary Group:	
ALWAYS review the written Parent	/Guardian medication instructions and Health Care	e Provider's medical order (when necessary according to r	egulation)
prior to EVERY administration. Inst	ructions should be attached to this sheet		

7 Rights MUST be performed with EVERY dose! Right child, Right medication, Right dose, Right route, Right time, Right reason, Right documentation

	Time	ne Dose	Dose Route dose Given Given giver	Time last dose was	Comments/Reactions	CONTROLLED SUBSTANCES				Quality	
		Given		given by Guardian		# on Hand	# Given	# Remain	Staff Signature	Staff Signature	Check

When medication has been discontinued, it should be returned to the parents or disposed of properly.