

MEDICATION ADMINISTRATION RECORD © 2004

(A separate authorization is required for each medication)

I, _____, give permission for _____

Parent Child Care Center

to give _____ the following medication:

Full First & Last Name

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.

Is the Medication Administration Record complete?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the medication in a child-resistant container?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the original prescription label on the medication container	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the child's first and last name on the container?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?)	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.