St. Johns Child Care Center
4842 Nicollet Avenue South
Minneapolis, MN 55419
Phone: (612) 827-1237 Fax: (612) 827-0574

MEDICATION ADMINSTRATION RECORD

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(A separate authorization is required for each medication)

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.

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 prescription current?	❑ Yes	❑ No
Is today's date before the expiration date?	❑ Yes	❑ No
Is the child's first and last name on the container?	❑ Yes	❑ No

Date										
Dose										
Time										
Initials										
Comments										

Date										
Dose										
Time										
Initials										
Comments										

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

Unused medication: Date returned to parents_____

*Physician signature not required on this form for prescription medication, in its original packaging, as it is needed to obtain prescription from the pharmacy. Place this form in child's file when medication is finished.