



AUTHORIZATION FOR MEDICATION/ADMINISTRATION RECORD

Name of Child _____ Date _____

TO BE COMPLETED BY PARENT

Medication _____

Dosage _____ Route _____ Frequency _____

Start Date _____ End Date _____ (Not to exceed 2 weeks for OTC Medication) *

Instruction for use _____

Condition for which prescribed _____

Possible side effects _____

Physician/Nurse Practitioner's Signature _____

(Required for OTC medication requiring medical consent, otherwise the pharmacy label indicates physician's permission)

PARENT/GUARDIAN: State Child Care Licensing regulations require a written authorization from parent/guardian in order for Sunny Hollow staff to administer medications (including non-prescription/over-the-counter).

- A separate authorization is required for EACH medication.
- Prescription medication must be in a labeled pharmacy container.
- Parent/Guardian is to give as many doses at home as possible.
- Parent/Guardian Signature (**Required**) _____

SUNNY HOLLOW STAFF: Please complete all four (4) blanks **for each dose given**. Signature required below.

	Monday		Tuesday		Wednesday		Thursday		Friday	
Date										
Time										
Dosage Given										
Initials										

	Monday		Tuesday		Wednesday		Thursday		Friday	
Date										
Time										
Dosage Given										
Initials										

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

Unused medication: Date returned to parents/Date discarded per parent's instructions _____

Staff: Please place this form in the child's office folder when medication is finished.

- There may be exceptions for children with chronic health conditions as defined by their care plan.