MEDICATION ADMINSTRATION RECORD

(A separate authorization is required for each medication) also known as"Medication Permission Form"

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?	❑ 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 child's first and last name on the container?	❑ Yes	❑ 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?)	❑ Yes	❑ 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.