CHILDREN FIRST CHILD DEVELOPMENT CENTER

Medication Permission and Documentation Form

Name of child: _____ Date: _____

Medication Name: _____ Dose: _____

Route: Oral _____ Topical _____ Inhaled _____ Injection _____ Storage Info: _____

Dates of Administration: _____ Expiration/Discontinue Date: _____

Time/Frequency of Administration: _____

Reason for Medication: _____

Prescription or OTC: _____

Other Information: (side effects, child preference, etc.) _____

Dates and Times of Last Dose Administered by Parent/Guardian:

Date	Time	Date	Time	Date	Time
_____	_____	_____	_____	_____	_____

Medication Allergies and Reactions: _____

Child's Health Care Provider and Contact Number: _____

Child's Health Care Provider Signature: _____ Date: _____

I request that the above state medication be given to the child named above in the manner as stated. I authorize CHILDREN FIRST CHILD DEVELOPMENT CENTER personnel to administer the medication. I release any liability in relation to the administration of this medication. I also acknowledge that I, the parent, have given the first dose of this medication without any allergic or unexpected reactions.

Parent/Guardian Printed Name: _____ Date: _____

Parent/Guardian Signature: _____

**An individualized written health care plan is required for the child who requires a nebulizer or inhaler*
**All medication must be in the original medicine/pharmacy bottle or package and labeled with the child's first and last name.*

In addition to the above information, the child's health care provider must issue a note with the following information:

*Child's first and last name
*Date of order
*Name of medication
*Reason for medication
Cannot state fever-reducer
*Possible adverse reaction, if any
*Dosage of medication
* Times and frequency to be administered
*Date to discontinue use
*Expiration date of medication
* Possible side effects
* Signature of prescribing authority

PLEASE SEE BACK FOR MEDICATION ADMINISTRATION LOG

STAFF USE ONLY: The following should be completed after each administration.

Name of Medication	Date Given	Time Given	Dose Given	Route of Delivery	Safety Check (7 Rights – See Below)	Child's Reaction/ Comments	Staff Signature (No initials)

SAFETY CHECK – 7 Rights performed prior to giving medications (must be done with each dose):

- Name of child is on original labeled container
- Name and Phone Number of health care provider
- Child-resistant container
- Original prescription or manufacturer's label
- Health provider's directions for use
- Current date (not expired or discontinued)

DISPOSAL / RETURN OF MEDICATION

Date: _____ Time: _____

Name of Medication: _____

Amount: _____ Form: _____

Method of Disposal: _____

Signatures of Two Staff Witnessing Disposal:

_____

Signature Printed Name

_____

Signature Printed Name