

OVER THE COUNTER Medication Administration in School or Child Care

The parent/guardian of _____ ask that school/child care staff give the
(Child's Name)
following medication _____ at **HRLC will administer medications at NOON ONLY**
(Name of Medicine and dosage) (Time(s))
to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

**The Program agrees to administer medication prescribed by a licensed health care provider.
It is the parent/guardian's responsibility to furnish the medication.
The parent/guardian agrees to pick up expired or unused medication within one week of notification by staff.**

Over the counter medication must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the nurse or school staff delegated to administer medication.

Parent/Legal Guardian's Name Parent/Legal Guardian Signature Date

Work Phone Home Phone

Health Care Provider Authorization to Administer Medication in School or Child Care

Child's Name: _____ Birth Date: _____

Medication: _____

Dosage: _____ Route: _____

To be given at the following time(s): _____

Special Instructions: _____

Purpose of medication: _____

Side effects that need to be reported: _____

Starting Date: _____ Ending Date: _____ **5 DAY MAXIMUM**

Signature of Health Care Provider with Prescriptive Authority License Number

Phone Number Date

Please ask the pharmacist for a separate medicine bottle to keep at school/child care. Thank you!

No "on-going" or "as needed" approvals will be permitted.

OFFICE USE ONLY: _____ Medication Administrator Signature Date Time Comments/Reactions
