PRESCRIPTION Medication Administration at Highlands Ranch Learning Center

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.

Prescription medications must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.

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: _____ **10 DAY MAXIUM**

_____ _____
Signature of Health Care Provider with Prescriptive Authority License Number

_____ _____
Phone Number Date

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

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

Fax to: 303-346-2457 **Highlands Ranch Learning Center** **Phone: 303-346-7144**