Medication Administration Form

Child's Name: _____ DOB: _____ Medication and Dose: _____

This program will administer medication to children for whom a plan has been made and approved by the Director. Because having medication in the facility can present a safety hazard, parents/guardians should check with the child's health care provider to see if a dose schedule can be arranged that does not involve the hours the child is in care by this facility. Parent/guardian may come to administer medication to their own child during the day.

Procedures for Medication in Licensed Child Care of Group Care Settings:

1. All medications/treatments require parent/guardian to complete and sign this Medication Administration Form.
2. All medications/treatments require the child's health care provider to complete and sign the bottom of this form or provide an appropriate written prescription.
3. Over-the-counter medication must be the original container and labeled with the child's name. Prescription medication must have a pharmacy label that corresponds with the written order from the health care provider.
4. All medications will be stored out of the reach of children and returned to the parents once prescription is completed. Parent is responsible for providing measuring devices (for example, a syringe) for accurate medication administration.
5. All medication administrations will be recorded by the staff administering the medication.
6. **Children with conditions such as asthma, severe allergies, diabetes, oxygen, feeding tubes and seizure disorder require a detailed health care plan in addition to, or in lieu of, this Medication Administration Form.** ***Please see staff for a copy of a health care plan.***

Medications:

- are administered in accordance with the pharmacy/medication label directions and as prescribed by the written instructions from the child's health care provider, which should match.
- The instructions form the child's parent/guardian shall not conflict with the label directions as prescribed by the child's health care provider.
- require a written prescription from the child's health care provider.

AUTHORIZATION FOR MEDICATION ADMINISTRATION

I hereby authorize delegated staff to administer the prescribed medication to my child as designated on this form.

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

Parent/Guardian name_____ Telephone _____

Parent/Guardian signature _____Date _____

In case of emergency, please contact _____ Telephone _____

Child's Health Care Provider name _____ Telephone _____

This portion may be completed by child's health care provider

Name of medication _____ Dosage _____ Time of administration_____

Route_____ Start date _____ End date_____

Purpose of medication _____Special instructions_____

Possible side effects _____

Health Care Provider signature _____ Date _____

Portions of this form taken from California Childcare Health Program and CDHS Medication Administration 2008 Handbook