Child Care Medication Authorization Form

Name of Child:_____D.O.B.:_____Today's Date:_____

Name of Medication:_____

Reason for Medication:_____

Dose:_____Time/Frequency: _____

Route: ☐ Oral ☐ Topical ☐ Inhaled ☐ Injection ☐ Other

Date to Start:_____Date to stop:_____Expiration:_____

Additional Instructions/Comments: _____

_____

Known side effects:_____

_____

FOR PRESCRIPTION MEDICATION

Prescribing Health Care Provider:_____

Phone Number: _____

FOR CONTROLLED SUBSTANCES

Amount of Medication Received:_____

Staff Member Signature:_____

Staff Member Signature:_____

I authorize (*child care center)* _____ personnel to administer the medication named above to my child in the manner as stated. I release any liability in relation to the administration of this medication. I also acknowledge that I, the parent/guardian, have given the first dose of this medication without any allergic or unexpected reactions.

Parent/guardian printed name: _____**Date Signed:** _____

Parent/guardian signature: _____

RETURN OR DISPOSAL OF MEDICATION

Return Date: _____ Parent Signature:_____

Disposal Date:_____ Staff Signature:_____

Witness to Disposal: _____