

# Child Care Medication Authorization Form

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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 Congdon Creek Preschool 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: \_\_\_\_\_

