MEDICATION ADMINSTRATION RECORD © 2012

(A separate authorization is required for each medication)

I, ______________________________ (Parent), give permission for ______________________________ (Child Care Center)

to give ______________________________ (Full First & Last Name) the following medication:

Medication: ______________________________

Amount/Dose: ______________________________

Time of Dose/Frequency: ______________________________

Route of administration: ❑Oral ❑Rectal ❑Topical ❑Inhaled ❑Eye/Nose/Ear ❑Other: __________

Start Date: __________________ End Date: __________________

Reason for Medication: ______________________________

Possible Side Effects: ______________________________

Physician Signature (for Over the Counter Medication*): ______________________________ **Date:** __________

Parents Signature: ______________________________ **Date:** __________

For Staff to Complete

Give medicine **only** if you can answer **yes** to all questions below.

Question	Yes	No
Is the Medication Administration Record complete?	❑ Yes	❑ No
Is the medication in a child-resistant container?	❑ Yes	❑ No
Is the original prescription label on the medication container?	❑ Yes	❑ No
Is the prescription current?	❑ Yes	❑ No
Is today's date before the expiration date?	❑ Yes	❑ No
Is the child's first and last name on the container?	❑ Yes	❑ No

Date										
Dose										
Time										
Initials										
Comments										

Date										
Dose										
Time										
Initials										
Comments										

Teacher's name (signature/initials)	Teacher's name (signature/initials)

Unused medication: Date returned to parents ______________________________

*Physician signature not required on this form for prescription medication, in its original packaging, as it is needed to obtain prescription from the pharmacy. Place this form in child's file when medication is finished.

Medication Administration Record

Date	Dose	Time	Given By	Comments