Medication Administration Packet

Authorization to Give Medicine
PAGE 1—TO BE COMPLETED BY PARENT/GUARDIAN

No medication will be administered to any child without the completion of this form. The medication must be delivered in the original & properly labeled container including expiration date. In the absence of a nurse, the designated staff will administer the medication.

Name of Facility/School _____ ____/____/____ Today's Date

Name of Child (First and Last) _____ ____/____/____ Date of Birth

Name of Medicine _____

Reason Medicine is needed during school hours _____

Dose _____ Route _____

Time to give medicine _____

Additional instructions _____

Needs Refrigeration ☐Yes ☐ No

Date to start medicine_____/_____/_____ Stop date_____/_____/_____

Known side effects of medicine _____

Plan of management of side effects _____

Child allergies _____

PRESCRIBER'S INFORMATION

Prescribing Health Professional's Name (Print) _____ Phone # _____

Prescribing Health Professional's Signature _____ Date ___/___/___

PERMISSION TO GIVE MEDICINE

I hereby give permission for the facility/school to administer medicine as prescribed above. **I also give permission for the caregiver or teacher to contact the prescribing health professional about the administration of this medicine. I have administered at least one dose of medicine to my child without adverse effects.**

_____
Parent or Guardian Name (Print)

_____
Parent or Guardian Signature

_____
Address

_____
Home Phone Number Work Phone Number Cell Phone Number