

# 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 Substance

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 of disposal of medication

Return Date: \_\_\_\_\_ Parent Signature: \_\_\_\_\_

Disposal Date: \_\_\_\_\_ Staff Signature: \_\_\_\_\_

Witness to Disposal: \_\_\_\_\_