Medication Administration Packet

Authorization to Give Medicine

PAGE 1—TO BE COMPLETED BY PARENT

CHILD'S INFORMATION

____ ____/____/____

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 ____

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

____

Phone Number

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/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

Adapted with permission from the NC Division of Child Development to the Department of Maternal and Child Health at the University of North Carolina at Chapel Hill, Connecticut Department of Public Health, and Healthy Child Care Pennsylvania.

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.
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