

Medication authorization form

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We can give your child medicine only with this signed form and the medicine in its original labeled container. Please fill out one form for each medicine and hand the medicine to a staff member. Don't leave it in your child's bag. If anything doesn't match this form or the label, we won't give the medicine, and we'll call you.

Child

Child's full name _____

Date of birth _____

Weight (if the dose depends on weight) _____

Allergies, including medicine allergies _____

Medicine

Check one.

☐ Prescription

☐ Non-prescription (over the counter)

Medicine name and strength _____

Reason for the medicine _____

Dose and how it's given (such as by mouth or inhaler) _____

Times to give it _____

For 'as needed' medicines: the signs that mean your child needs it, and how often it may be given _____

Start and end dates _____

Expiration date (we don't give expired medicine) _____

Prescriber's name and phone (for prescriptions) _____

How to store it (such as in the refrigerator) _____

Side effects to watch for _____

Last dose given at home (date and time) _____

Before the first dose

Check each one that's true.

☐ My child has taken this medicine before without a problem

☐ The medicine is in its original container, labeled with my child's name (for prescriptions, with the pharmacy label)

☐ The dose on this form matches the label or the doctor's written instructions

Emergency medicines

For epinephrine auto-injectors, asthma inhalers and other emergency medicines, please attach your child's action plan from their health care provider.

☐ Allergy or asthma action plan attached

Health care provider's instructions (if required)

[Our program or our state] requires written instructions from the child's health care provider for [prescription medicines, some non-prescription medicines and any dose that's different from the label].

Health care provider's printed name and phone _____

Health care provider signature and date _____

Parent or guardian permission

I give permission for trained program staff to give my child the medicine on this form, as described here and on the label. I'll tell the program in writing if anything changes, and I'll pick up any medicine that's left after the end date.

Parent or guardian's printed name _____

Parent or guardian signature _____

Date _____

Phone during the day _____

For program use

Received by (staff) and date _____

Medicine checked against the label and this form (initials)

Medication log started (date) _____

Medicine returned to the parent (date and amount left)

Free to use and change, but not legal or medical advice. Check your state's licensing rules and your insurer's requirements, and have a lawyer review any consent or waiver language.

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