**Parent’s Authorization**

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| Child’s Name: | Child’s Teacher’s Name: | Prescribing Physician: |
| Name of Medication: | Dosage (How Much): | Route (Example: Oral) |
| Schedule (Example: As needed): | Reason Taken: | Expiration Date of Medication: |
| Start Medication (Date): | Continue Medication Until (Date): | Refrigeration Required: |
| Possible Side Effects: | | Emergency Contact Information: |

**NOTE:** Medications (Prescribed and Over the Counter) must be in its original container, labeled with the child’s name, with directions on how and when to administer the medication, and the date medication is left at the facility. Medication can only be administered in amounts according to the prescription or medical provider directions. Expired medications will NOT be accepted. I hereby request an employee to administer the medication named below to my child. By signing below I release the child-care center and its employees from all liability for reactions which my child may suffer from this medication.

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| Printed Name - Parent or Guardian Signature – Parent or Guardian Date |

**Medicine Check List:**

Accept medicine ***ONLY*** if you can answer ***YES*** to all the questions below (please circle):

* Authorization form signed by parent or guardian: Yes No
* Medication in original (child-proof) container: Yes No
* Medication labeled with the child’s name: Yes No
* Prescription label or medical provider’s directions with medication: Yes No
* Measuring device or medication equipment available (if needed): Yes No
* Expiration date checked (Do NOT accept expired medication): Yes No

HS/EHS Staff’s Signature (Please sign legibly): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_