Administration of Prescribed and Non Prescribed Medication

Child's Name: _____ Date of Birth: _____ Sex: M ☐ F ☐

Home Child Care Caregiver: _____

Dispensing Pharmacist (If Applicable): _____Phone: _____

Doctors Name (If Applicable): _____Phone: _____

I authorize the administration of the following prescription/non-prescription medication(s) by the home child care caregiver, and am providing the above medication **in its original container and labelled with my child's name and the correct dosage.**

Name of Medication: _____

Start Date:_____ **Stop Date:**_____

Dosage: _____ **Schedule:** _____

Dosage and schedule of administration must match the label

I understand only the primary caregiver will administer the medication.
I understand and accept that if questions arise about giving/applying the medication, the caregiver may contact the dispensing pharmacy to clarify the issue.
I understand and accept that if problems arise with the giving/applying of the medication the caregiver will stop giving/applying the medication and will notify me and the Home Child Care consultant. I understand that a caregiver may choose not to administer any medications.

Comments / Directions: (If medication is to be administered "as needed", please note symptoms which need to be present before administration of medication.)

It is my understanding my child is permitted to carry and administer their asthma medication or emergency allergy medications and will advise caregiver of its use.

Yes ____ No_____ Initial _____

_____ _____
Parent's Signature Date

Parents must initial the form daily to indicate that they are aware of the child receiving medication. (In the case of ongoing medications, form may be signed once every two weeks.)

Caregivers must initial the form each time they administer medication.

Date	Medication Prescribed/Non Prescribed	Dosage	Time Given	Caregiver Initials	Parents Initials

Completed form is to be submitted to the Home Child Care Office