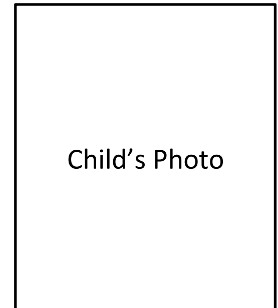
# Parent/Guardian Authorization for Medication Administration at School and Medication Administration Record Form

Center: ______________________________ ☐ Early Head Start ☐ Head Start ☐ ECEAP

I request the designated school nurse, principal, center director, or staff member be permitted to dispense to my child the medication prescribed by child's Health Care Provider.




Child's Name: ______________________________ Program Year: __________

Health Care Provider's Name: ______________________________

**This authorization is valid for the current school year only.**

The medication is to be furnished by me in the original, unopened container, labeled by the pharmacy including the Health Care Provider's name, the name of the medicine, the amount to be taken, and the time of day to be taken. I understand that my signature indicates I am the parent or the legal guardian of the this child and I understand that the school accepts no liability for any adverse reactions when the medication is administered in accordance with the Health Care Provider's directions. In case of necessity, the school district/Early Learning program may discontinue administration of the medication with proper advanced notice. I understand that if I am notified by the school/Early Learning personnel that there is any unused medication after the course of treatment, **I will collect the unused portion of the medication from the school or it will be destroyed**.

Medication: ______________________________ ☐ PRN Spacer: ☐ Yes ☐ No

Purpose: ______________________________

Dosage: ____________________ Times(s) to be given: ____________________

Route: ______________ Start date: ______________ End date: ______________

Potential side effects: ______________________________

Date received: ____________________ Amount received: ____________________

Pharmacy label expiration date: ______________ Manufacturer expiration date: ______________

☐ Above information is consistant with label ☐ Requires refrigeration

______________________________

Parent/Guardian Signature Date

______________________________

Interpreter Signature Date

______________________________

Staff Signature Date

______________________________

Reviewed by: Health or Nutrition Coordinator / Nurse Consultant Date

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Child's Name: ________________________ DOB: ____________ Gender: M / F

Select code and enter in Time column below when regularly scheduled medication not given.

**Codes:** **A =** Child Absent **X =** No class **N =** None Available
**D.C. =** Medication Discontinued **E =** Medication not given (Write explanation in Child/Family file)

Record all reactions and/or behavior changes under "Observations" column. Notify parent and document in Family File.

| Date | Time | Initial | Observations | Date | Time | Initials | Observations |
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Please complete if you initialed above.

| Print Name | Signature | Initials |
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