MEDICATION ADMINISTRATION IN SCHOOL OR CHILD CARE

The parent/guardian of _____ **ask that school/child care staff give the**
CHILD'S NAME

following medication _____ at _____
NAME OF MEDICINE AND DOSAGE TIME(S)

to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

Qualified Medication Administration Personnel of Campbell Child & Family Center agrees to administer medication prescribed by a licensed health care provider.
It is the parent/guardian's responsibility to furnish the medication.
The parent/guardian agrees to pick up expired or unused medication within one week of notification by staff.

Prescription medications must come in a container labeled with: CHILD'S NAME, NAME OF MEDICINE, TIME MEDICINE IS TO BE GIVEN, DOSAGE, DATE MEDICINE IS TO BE STOPPED, and LICENSED HEALTH CARE PROVIDER'S NAME. Pharmacy name and phone number must also be included on the label.

Over-The-Counter medication must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the nurse or school staff delegated to administer medication.

PARENT/LEGAL GUARDIAN'S **PRINTED NAME**	PARENT/LEGAL GUARDIAN'S **SIGNATURE**	DATE
PARENT/GUARDIAN/S **WORK** PHONE	PARENT/GUARDIAN/S **HOME** PHONE	

THIS PORTION RESERVED FOR HEALTH CARE PROVIDER

HEALTH CARE PROVIDER AUTHORIZATION TO ADMINISTER MEDICATION IN SCHOOL OR CHILD CARE

CHILD'S NAME	**BIRTHDATE**
MEDICATION	
DOSAGE	**ROUTE**
TO BE GIVEN AT THE FOLLOWING TIME(S)	
SPECIAL INSTRUCTIONS	
PURPOSE OF MEDICATION	
SIDE EFFECTS THAT NEED TO BE REPORTED	
STARTING DATE	**ENDING DATE**
SIGNATURE OF HEALTH CARE PROVIDER WITH PRESCRIPTIVE AUTHORITY	**LICENSE NUMBER**
PHONE NUMBER	**DATE**

Please ask the pharmacist for a separate medicine bottle to keep at school/childcare. Thank YOU!