Authorization for Medication

Please COMPLETE the entire form.

No medication shall be given without a COMPLETE, SIGNED permission from the parent/guardian.

Child's Name: _____ Age:_____

Name of Medication & Prescription Number: _____

Medication has to be refrigerated: ☐Yes ☐No

Reason Medication is Being Administered:_____

Amount of Medication to be Given:_____

Dates to be Given: Times Medication is to be Given:

*_____ ☐12:00 pm ☐4:00 pm ☐Other *_____

** A new form must be completed each calendar week. *Per Written Directions from the Child;s Physician or Non-Prescription Topical Ointments*

Medication has been previously administered to the child without adverse effects: ☐ Yes ☐ No

**Medication will not be administered by the child care center unless the child has previously received the medication.*

Possible side Effects:_____

Action to Take if Side Effects are Noted:_____

Special Directions:_____

**Any directions which conflict with the medication label will require written approval from the child's physician.*

Food/Medication Allergies:_____

Parent/Guardian Authorization Medication:

Name: _____Relationship:_____ Phone:_____

Signature _____ Date: _____

By signing this form, the Guardian releases Lil' Voyagers Academy, its Owners, Directors, Administrators & Employees from any claims & liability for administering of Medication.

Date	Time	Medication	Method	Amount of Dosage	Adverse Effects	*Signature of Person Administering*

For Internal Use Only

List reactions indicating medication should be discontinued and call parent/guardian immediately:

_____

If there was an error in the administration of medication or medication was not administered at the time listed above, **call parent/guardian immediately** and indicate at what time and why:_____

_____

On _____, any remaining medication has been: ☐Returned to the parent ☐ Disposed of ☐ Other
(Date)

Director's Signature:_____ Date :_____