

# Medication Authorization

Child's Name: \_\_\_\_\_

Classroom: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Prescription #: \_\_\_\_\_

*Required for all prescriptions*

Circle a max of 10 days; if days go into next month, please complete an additional form for next month.

Month: Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec

Day: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Time(s): 10:30 and/or 2:30 (can NOT give as needed)

Dosage: \_\_\_\_\_ (If dosage does not match what is on medication, we must have a doctor's note.)

Please list any other medications your child is currently taking:

I authorize a Foundations for the Future employee to administer medication to my child as outlined above, and I understand that the school and its employees are not liable for any effects that may occur.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## FOR CENTER USE ONLY—ONLY DISPENSE MEDICATION AFTER THIS SECTION COMPLETED

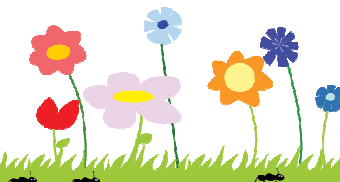
|  |     |    |
|--|-----|----|
| Is the medication in original container?                                 | Yes | No |
| Is the expiration date current?  | Yes | No |
| Is the container labeled with child's name?                              | Yes | No |
| Does the dosage on this form match the dosage recommended on bottle?     | Yes | No |
| Is there an appropriate dispenser/measurer provided & labeled with name? | Yes | No |

If all of the answers to the above questions are "Yes", then reviewing employee sign and date below.

Employee Reviewer's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Next, turn this form over, and fill in the dates selected above in the appropriate box for each date and time to be given.



# Medication Authorization

Child's Name: \_\_\_\_\_

Classroom: \_\_\_\_\_

**CROSS OUT THIS SECTION IF MED SHOULD NOT BE ADMINISTERED AT 10:30**

| Date | Scheduled Time | Actual Time or Absent* | Dosage | Teacher Verifier** | Administered By | Adverse Reaction? Y/N*** |
|------|----------------|------------------------|--------|--------------------|-----------------|--------------------------|
|      | 10:30          |                        |        |                    |                 |                          |
|      | 10:30          |                        |        |                    |                 |                          |
|      | 10:30          |                        |        |                    |                 |                          |
|      | 10:30          |                        |        |                    |                 |                          |
|      | 10:30          |                        |        |                    |                 |                          |
|      | 10:30          |                        |        |                    |                 |                          |
|      | 10:30          |                        |        |                    |                 |                          |
|      | 10:30          |                        |        |                    |                 |                          |
|      | 10:30          |                        |        |                    |                 |                          |
|      | 10:30          |                        |        |                    |                 |                          |

**CROSS OUT THIS SECTION IF MED SHOULD NOT BE ADMINISTERED AT 2:30**

| Date | Scheduled Time | Actual Time or Absent* | Dosage | Teacher Verifier Signature** | Administered By Signature | Adverse Reaction? Y/N*** |
|------|----------------|------------------------|--------|------------------------------|---------------------------|--------------------------|
|      | 2:30           |                        |        |                              |                           |                          |
|      | 2:30           |                        |        |                              |                           |                          |
|      | 2:30           |                        |        |                              |                           |                          |
|      | 2:30           |                        |        |                              |                           |                          |
|      | 2:30           |                        |        |                              |                           |                          |
|      | 2:30           |                        |        |                              |                           |                          |
|      | 2:30           |                        |        |                              |                           |                          |
|      | 2:30           |                        |        |                              |                           |                          |
|      | 2:30           |                        |        |                              |                           |                          |
|      | 2:30           |                        |        |                              |                           |                          |

\*Give within 15 minutes of scheduled time; if more than 15 minutes from scheduled time, call for parent permission to dispense medication. If child not in attendance at this time, write in "absent."

\*\*Teacher verifies identity of child, appropriate dosage time and dosage amount on other side of form.

\*\*\*If child experiences an adverse reaction, call 911 immediately and then notify parents. Attach a separate sheet documenting adverse reaction and actions taken.

