Form A

Over the Counter Medication Authorization Form

NOTE: Medication shall not be administered to any child in childcare if not prescribed or recommended by a licensed health care provider (physician, dentist, nurse practitioner).

Child's Name ___________________________ Medication Name ___________________________

Parents Emergency Numbers ___________________________

Date Medication Brought to Center _______ Medication Expiration Date ______

Physician's Name ___________________________ Address ___________________________

Office Number ___________________________

Emergency Number ___________________________

Frequency and Time Medication is to be Administered ___________________________
If “PRN” or “as needed” a clear explanation is required ___________________________

Route and Dosage of Medication ___________________________

Directions for Storage ___________________________

Directions for Disposal (Please check one of the following)

_______ Send Home _______ Destroy and Dispose of in Appropriate Container

Please attach a written statement of desired effects, side effects and specific instructions. Medication must be brought into the center by a parent and must be kept in the original container. Please attach written instructions received from physician. In order for this center to administer the medication fore mentioned, please sign below.

Parent Signature ___________________________ Date ___________________________

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Office Use Only

1) Staff Member Administering Medication:

Date ______ Time ____ Dosage ____ Safety Check Complete ______ 45 minute Observation ______ Initial

2) Staff Member Administering Medication:

Date ______ Time ____ Dosage ____ Safety Check Complete ______ 45 minute Observation ______ Initial

3) Staff Member Administering Medication:

Date ______ Time ____ Dosage ____ Safety Check Complete ______ 45 minute Observation ______ Initial

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