AUTHORIZATION TO ADMINISTER PRESCRIPTION AND NON PRESCRIPTION MEDICATION

IN ACCORDANCE WITH HE C 4002.18, THIS FORM MUST BE COMPLETED PRIOR TO THE ADMINISTRATION OF ANY PRESCRIPTION OR NON-PRESCRIPTION MEDICATION.

PRESCRIPTION MEDICATION WILL BE ADMINISTERED IN ACCORDANCE WITH THE PRINTED PRESCRIPTION LABEL, WHICH MUST BE ATTACHED TO THE ORIGINAL PRESCRIPTION CONTAINER.

NON-PRESCRIPTION MEDICATION MUST BE IN ORIGINAL CONTAINER, AND WILL BE ADMINISTERED IN ACCORDANCE WITH THE MANUFACTURER'S PRINTED INSTRUCTIONS. IF THERE ARE NO MANUFACTURER'S PRINTED INSTRUCTIONS FOR THE AGE OF THE CHILD, THE PROGRAM MAY ADMINISTER THE NON-PRESCRIPTION MEDICATION IN ACCORDANCE WITH THE WRITTEN, DATED AND SIGNED INSTRUCTIONS FROM THE CHILD'S PARENT, INCLUDING A STATEMENT THAT THE INSTRUCTIONS HAVE BEEN REVIEWED/APPROVED BY THE CHILD'S LICENSED HEALTH PRACTITIONER, OR WITH SIGNED, DATED WRITTEN INSTRUCTIONS FROM CHILD'S LICENSED HEALTH PRACTITIONER.

PARENT'S AUTHORIZATION

I AUTHORIZE CHILD CARE PERSONNEL AT ______________________________ TO ADMINISTER THE
NAME OF CHILD CARE PROGRAM

FOLLOWING MEDICATION TO MY CHILD: ______________________________ ____________
CHILD'S NAME DATE OF BIRTH

NAME OF MEDICATION	DOSAGE	TIMES TO ADMINISTER	BEGINNING DATE	ENDING DATE

____
PRINTED NAME AND PHONE NUMBER OF CHILD'S LICENSED HEALTH PRACTITIONER

______________________________ ____________
PARENT/GUARDIAN'S SIGNATURE **DATE SIGNED**

SPECIAL INSTRUCTIONS FOR ADMINISTRATION OF NON-PRESCRIPTION MEDICATION:

THE ABOVE SPECIAL INSTRUCTIONS WERE:
- ☐ **REVIEWED AND APPROVED BY THE ABOVE NAMED LICENSED HEALTH PRACTITIONER**
- ☐ **COMPLETED BY THE LICENSED HEALTH PRACTITIONER WHO'S SIGNATURE IS BELOW**

______________________________ ____________
LICENSED HEALTH PRACTITIONER'S SIGNATURE **DATE SIGNED**

CHILD CARE PROGRAM RECORD OF MEDICATION ADMINISTRATION

(TO BE COMPLETED BY CHILD CARE PERSONNEL FOR ALL MEDICATION ADMINISTERED)

NAME OF MEDICATION	AMOUNT	TIME	DATE	INITIALS

NAME OF MEDICATION	AMOUNT	TIME	DATE	INITIALS

NAME OF MEDICATION	AMOUNT	TIME	DATE	INITIALS

NAME OF MEDICATION	AMOUNT	TIME	DATE	INITIALS

______________________________ ____________
SIGNATURE AND POSITION TITLE OF PERSON SUPERVISING ADMINISTRATION/CONTROL OF MEDICATION DATE SIGNED