Permission to Administer Medication in Haddonfield Child Care

(Please use one form per medication.)

To be completed by the child's HEALTH CARE PROVIDER

Health care provider please note: medication will be received and administered by non-medical child care staff; therefore, please type or print clearly, and do not use abbreviations.

This portion may be completed by the parent or guardian ONLY if it is attached to a matching special health care plan.

Child's name: _____ Birthdate: _____

Medication: _____ Allergies: _____

Dosage: _____ Route:_____

Time(s) of day medication is to be given: _____

Purpose of medication: _____

Special instructions: _____

If asthma inhaler, is child permitted/trained to self-medicate? _____

Possible side effects: _____

Start date: _____ End date: _____

_____ _____ _____

Signature of Health Care Provider *Phone number* *Date*

To be completed by the PARENT OR GUARDIAN

I hereby give permission for my child, _____, to receive the above medication, according to the listed directions and cautions, from the HCC program staff members as designated by the Executive Director. I confirm that I have given at least one dose of the medication without any evidence of side effects or adverse reactions. I understand that it is my responsibility to provide the medication in its original container and labeled with my child's name. I am also to supply the appropriate measuring device needed to give the accurate dose of the medicine.

I authorize the Director or Director Designee to contact the pharmacist or health care provider for more information about this drug, if necessary.

I usually do the following to make giving medication to my child easier: _____

_____

Amount of medication brought to Child Care: _____

Expiration Date: _____

Date_____ _____

Signature of Parent or Guardian

To be completed by the HCC DIRECTOR OR DESIGNATE upon receipt of medication

I confirm that I have examined the medication provided and determined that the label matches the information above and the quantity is as indicated above.

I have asked the parent/guardian to clarify the following questions/concerns:

_____

_____

Date_____ _____

Signature of HCC Designate

To be completed by the HCC DIRECTOR OR DESIGNATE at the end of the medication period

Amount of medication returned to parent/guardian _____ Date_____

Signature of Parent/Guardian _____

Signature of HCC Designate _____