

MEDICATION ADMINISTRATION RECORD © 2007

(A separate authorization is required for each medication)

I, _____, give permission for _____
Parent Child Care Center

to give _____ the following medication:
Full First & Last Name

Medication: _____
 Amount/Dose: _____
 Time of Dose/Frequency: _____
 Route of administration: Oral Rectal Topical Inhaled Eye/Nose/Ear Other: _____
 Start Date: _____ End Date: _____
 Reason for Medication: _____
 Possible Side Effects: _____
 Physician Signature (for Over the Counter Medication): _____ Date: _____
 Parents Signature: _____ Date: _____

For Staff to Complete

Give medicine only if you can answer yes to all questions below.

Is the Medication Administration Record complete?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the medication in a child-resistant container?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the original prescription label on the medication container?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the prescription current?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is today's date before the expiration date?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the child's first and last name on the container?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Dose							
Date							
Time							
Initials							
Comments							

Dose							
Date							
Time							
Initials							
Comments							

Teacher's name (signature/initials)	Teacher's name (signature/initials)

Unused medication: Date returned to parents _____

Place this form in child's file when medication is finished.