

## MEDICATION ADMINISTRATION RECORD © 2004

(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 child's first and last name on the container?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the date on prescription current? (Within the month for antibiotics and within the expiration date for medications which are so labeled; within the year otherwise?)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

	Monday	Tuesday	Wednesday	Thursday	Friday
<b>Dose</b>					
<b>Date</b>					
<b>Time</b>					
<b>Initials</b>					
<b>Comments</b>					

	Monday	Tuesday	Wednesday	Thursday	Friday
<b>Dose</b>					
<b>Date</b>					
<b>Time</b>					
<b>Initials</b>					
<b>Comments</b>					

<b>Teacher's name (signature/initials)</b>	<b>Teacher's name (signature/initials)</b>

Unused medication: Date returned to parents \_\_\_\_\_

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