

Archway Programs Just Kids

Office use only:
Medication Administration Approved:

Director _____

Date _____

Permission to Administer Medication

(Please use one form per specific medication.)

The following information is to be completed by the child's health care provider:

Child's name: _____ Birthdate: _____

Medication: _____ Allergies: _____

Dosage: _____ Route: _____

When and how often medication is to be given: _____

Please check one. Self Administration Administration by staff

Purpose of medication: _____

Special instructions: _____

Possible side effects: _____

Start date: _____ End date: _____

Signature of Health Care Provider

Phone number

Date

*** If medication is to be administered on an "as needed basis" – Health Emergency Plan form or Asthma Treatment Plan must be completed as well.**

The following is 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 designated Just Kids provider. 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.

Signature of Parent or Guardian

Date

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

Amount of medication brought to Just Kids: _____

Date _____

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Medication and amount returned to Parent: _____

Signature of Supervisor

Signature of Parent of Guardian

Date