CCYC Medication Authorization Form

Month:_____

Child's Name:_____ Date(s):_____

Name of medication:_____ Dosage amount:_____

Reason to be given to Child:_____Time to be given:_____

Medication Expiration Date:_____ Storage location:_____

All prescription and non-prescription medications require written authorization from both the prescribing physician and the child's parent. Each medication must be in the original container, complete with administration instructions, and intact label. Each non-prescription medication must be accompanied with a doctor's note, in the original container labeled with the child's name, be age appropriate for the child, and have clear and complete instructions from the prescribing physician on route and dosage. This authorization is valid for a maximum of one month and then must be reauthorized for all future dates. Medications must be recorded every day they are administered. If medication is not administered for any reason you must make a note as to the reason that it was not administered.

I authorize the Creative Center for Young Children staff to administer the following medication to my child as specified by my child's doctor.

_____

Signature of Parent **Date**

Date	Amount Given	Time Given	Staff Initials	Notes

Date	Amount Given	Time Given	Staff Initials	Notes