

Medication Administration Packet

Authorization to Give Medicine
PAGE 1—TO BE COMPLETED BY PARENT

CHILD'S INFORMATION

Name of Facility/School _____ / /
Today's Date

Name of Child (First and Last) _____ / /
Date of Birth

Name of Medicine _____

Reason medicine is needed during school hours _____

Dose _____ Route _____

Time to give medicine _____

Additional instructions _____

Date to start medicine / / Stop date / /

Known side effects of medicine _____

Plan of management of side effects _____

Child allergies _____

PRESCRIBER'S INFORMATION

Prescribing Health Professional's Name _____

Phone Number _____

PERMISSION TO GIVE MEDICINE

I hereby give permission for the facility/school to administer medicine as prescribed above. **I also give permission for the caregiver/teacher to contact the prescribing health professional about the administration of this medicine. I have administered at least one dose of medicine to my child without adverse effects.**

Parent or Guardian Name (Print) _____

Parent or Guardian Signature _____

Address _____

Home Phone Number _____

Work Phone Number _____

Cell Phone Number _____

Receiving Medication

PAGE 2—TO BE COMPLETED BY CAREGIVER/TEACHER

Name of child _____

Name of medicine _____

Date medicine was received ____/____/____

Weight of child _____

Safety Check

- 1. Child-resistant container.
- 2. Original prescription or manufacturer's label with the name and strength of the medicine.
- 3. Name of child on container is correct (first and last names).
- 4. Current date on prescription/expiration label covers period when medicine is to be given.
- 5. Name and phone number of licensed health care professional who ordered medicine is on container or on file.
- 6. Copy of Child Health Record is on file.
- 7. Instructions are clear for dose, route, and time to give medicine.
- 8. Instructions are clear for storage (eg, temperature) and medicine has been safely stored.
- 9. Child has had a previous trial dose.

Y N 10. Is this a controlled substance? If yes, special storage and log may be needed.

Caregiver/Teacher Name (Print)

Caregiver/Teacher Signature

Medication Log

PAGE 3—TO BE COMPLETED BY CAREGIVER/TEACHER

Name of child _____ Weight of child _____

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____
Dosage/amount					
Route					
Staff signature					

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____
Dosage/amount					
Route					
Staff signature					

Describe error/problem in detail in a Medical Incident Form. Observations can be noted here.

Date/time	Error/problem/reaction to medication	Action taken	Name of parent/guardian notified and time/date	Caregiver/teacher signature

RETURNED to parent/guardian	Date	Parent/guardian signature	Caregiver/teacher signature
	/ /		
DISPOSED of medicine	Date	Caregiver/teacher signature	Witness signature
	/ /		