

Prescription Medication Authorization / Administration Form

TO BE COMPLETED BY PARENT / GUARDIAN

Child's Name: _____ Date of Birth: __/__/__
 Program Name: _____ Today's Date: __/__/__

To administer a prescription medication:

- The medication must be in its original container with a legible label from the pharmacy indicating the child's name, date, name of medication, dosage, instructions for use, doctor's / nurse practitioner's name, pharmacy name and phone number.
- Samples must be accompanied by a doctor's written prescription
- Medications are to be given only to the child indicated on the label. Twins and siblings cannot share.
- A separate authorization is required for each medication and each episode of illness.
- Label constitutes the physician's / nurse practitioner's order.
- Parent / Guardian is to give as many doses as possible at home.

Medication: _____

Reason for giving: _____

Start Date: __/__/__ End Date: __/__/__

Dosage: _____ Time(s) to be given at Day Camp: _____ a.m. _____ p.m.

Last dose was given at _____ a.m. / p.m. on date __/__/__

Route: by mouth, skin (location) _____, eye (R/L), ear (R/L)

Possible side effect: _____

Special Handling / storage instructions: _____ Refrigeration: Yes / No

Parent / Guardian Signature required: _____

Physician / Nurse Practitioner's Signature: _____

(For over-the-counter medication requiring medical consent, otherwise, the pharmacy label indicates the physician's permission)

Staff must record for each dose given with signature below

Days	Date	Time	Dosage	Safety Check	Signature
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					

Unused Medication (circle one): Return to Parent

Discard appropriately

****Keep this form in the child's file when medication is finished.***