Jennifer-James Daycare

Authorization for the Administration of Medication by Child Day Care Personnel

Parents/guardians requesting medication administration to their child by Jennifer-James daycare staff shall provide the program with appropriate written authorization(s) and the medication before any medications are dispensed. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription. All unused medication will be destroyed if not picked up within one week following the termination of the authorized prescriber's order.

Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):

Name of Child _____ Date of Birth ____/____/____ Today's Date ____/____/__

Medication Name _____ Controlled Drug? ☐ YES ☐ NO

Dosage _____ Method _____ Time of Administration_____

Specific Instructions for Medication Administration _____
Medication Administration Start Date ____/____/____ Stop Date ____/____/____

Is this medication to be self-administered by the child? ☐ Yes ☐ No

Relevant Side Effects of Medication _____

Plan of Management for Side Effects _____

Known Food or Drug: Allergies? ☐ YES ☐ NO Reactions to? ☐ YES ☐ NO Interactions with? ☐ YES ☐ NO

If "yes" to any of the above, please explain _____

Prescriber's Name _____ Phone Number (_____)_____

Prescriber's Address _____ Town _____

Signature _____

Parent/Guardian Authorization:

☐ I request that medication be administered to my child as described and directed above and attest that **I have administered at least one dose of the medication to my child without adverse effects.**

☐ I request that medication be self-administered to my child as described and directed above.

Name of Day Care Program : Jennifer-James Daycare Today's Date _____/____/_____

Child's Name _____ Address _____Town_____

Name of Parent/Guardian Authorizing Administration of Medication _____

Relationship to Child: ☐ Mother ☐ Father ☐ Guardian/Other explain: _____

Address _____ Town _____Phone Number (____) _____

Signature of Parent/Guardian Authorizing Administration of Medication _____

Name of Childcare Personnel Receiving Written Authorization and Medication _____

Title/Position _____ **Signature (in ink)** _____

Medication Administration Record (MAR)

Name of Child _____ **Date of Birth** _____/_____/_____

Pharmacy Name _____ **Prescription Number** _____

Medication Order_____

Date	Time	Dosage	Remarks	Was This Medication Self Administered?	Signature of Person Observing or Administering Medication
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

*Medication authorization form must be used as either a two-sided document or attached first and second page.

☐ **Authorization form is complete** ☐ **Medication is appropriately labeled**

☐ **Medication is in original container** ☐ **Date on label is current**

Person Accepting Medication (print name)_____ **Date** _____/_____/_____