Chestnut Hill ACADEMY

CHILD CARE MEDICATION AUTHORIZATION FORM

A school-age provider must not give medication to any child without written and signed consent from that child's parent or guardian, must administer medication pursuant to directions on the medication label, and must use appropriate clean and sanitized medication measuring devices.

Child's full name (first and last):		Child's Birthdate:
Name of Medication (as it appears on medication container):		
Dosage:	Start Date:	End Date:
To be given at the following times:		
Reason for Giving Medication to Child/Medical Need:		
Possible Side Effects of Medication:		
Additional Information:		

Prescription medication must only be given to the child named on the prescription. Prescription medication must be labeled with: child's first and last name, the date the prescription was filled, the name and contact information of the prescribing health professional, the expiration date, dosage amount, length of time to give the medication, and instructions for administration and storage.

Nonprescription (over-the-counter) medication must be brought to the early learning or school-age program by the child's parent or guardian in the original packaging with expiration date and labeled with the child's first and last name. It must only be given to the child named on the label provided by the parent or guardian. Instructions on the label must be followed, unless the parent or guardian provides a medical professional's note.

If the packaging label does not include expiration date, dosage amount, age, and length of time to give the medication, then written authorization from a health care provider with prescriptive authority is required, as well as the written and signed consent from the child's parent or guardian. This includes: vitamins, herbal supplements, fluoride supplements, homeopathic or naturopathic medication, and teething gels or tablets (amber bead necklaces are prohibited).

I hereby give permission for the staff of Chestnut Hill Academy to give my child the medication as prescribed above.

_____ _____

Parent/Guardian Signature *Date*

This section to be completed by child's parent or guardian, if applicable:

*I, or my appointed designee, have provided training about specialized medication administration procedures for my child specific to this medication to the following staff member(s):*_____

_____ _____

Parent/Guardian (or Designee) Signature Date *School Age Provider Signature Date*