MEDICATION AUTHORIZATION

This child requires the administration of medication during program time:

Name of Child: _____ Date: _____

To be completed by child's parent or guardian:

I, _____ (parent/guardian's name), am requesting that the following medication be administered by child care staff according to the instructions stated below to _____ (child's name).

Parent/guardian's signature: _____

Name of Medication: _____

Amount(s) to be given: _____

Date(s) to be given (at child care): _____

Time(s) to be given: _____

Special Instructions: _____

Storage: _____

Start date: _____ **End Date:** _____

My child received _____ (number) doses at home.

Are there any possible side effects from the medication? Please specify: _____

_____

_____

Stop medication if the following reaction(s) is observed: _____

_____

To be completed by the child care provider:

I, Eduardo Hermosa (Recreation Coordinator), agree to have SEAPARC program staff administer the medication according to the instructions provided by the parent/guardian above.

Recreation Coordinator Signature: _____

Medication Record

(To be completed by child care provider when medication is given)

DATE	TIME	DOSAGE	COMMENTS	GIVEN BY: (staff name)

The personal information contained on this form is collected in accordance with the Freedom of Information and Protection of Privacy Act, and will only be used for the purpose for which it is collected.

MEDICATION AUTHORIZATION

Medication Record Continued

(To be completed by child care provider when medication is given)

DATE	TIME	DOSAGE	COMMENTS	GIVEN BY: (staff name)

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