Parent Permission Is Required For:
Sunscreen, Toothpaste, Bug Spray, Lip Balm and Non-Medicated Diaper Cream
****Anything else must have a signed prescription from the Doctor****

Medication Authorization Form

To be Completed by Parent/Guardian

Name of Child (First, Last)	Date of Birth (Mo/Day/Year)
Today's Date	
Allergies	
Name of Medicine	
Reason medicine is needed during school hours	
Dose	Route
Time or frequency to give medicine (i.e. 8:00 am and 2:00 pm or every 6 Hours)	
Additional instructions	
Date to start medicine__/___/____	Stop date___/___/____

Known side effects of medicine (e.g. Benadryl® may cause drowsiness)

Plan of management of side effects

PRESCRIBER'S INFORMATION

Prescribing Health Professional's Name	Phone Number

PERMISISON TO GIVE MEDICINE

I hereby give permission for Coeur D' Alene Learning Center to administer medicine as prescribed above. **I also give permission for Coeur D' Alene Learning Center 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

Primary Phone Number	Secondary Phone Number	Emergency Phone Number

**This Form must be completed prior to administering any medication*

Receiving Medication

To be Completed by Staff

Name of child
Name of medicine
Date medicine was received

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 (e.g. 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 witness is required.

_____

Staff Name (Print)

_____

Staff Signature

Medication Administration Log

Child:				Medication:	
Week 1	Date	Time	Dose	Route	Staff Signature (&Witness if controlled medication)
Monday		AM			
		PM			
Tuesday		AM			
		PM			
Wednesday		AM			
		PM			
Thursday		AM			
		PM			
Friday		AM			
		PM			

Week 2	Date	Time	Dose	Route	Staff Signature (&Witness if controlled medication)
Monday		AM			
		PM			
Tuesday		AM			
		PM			
Wednesday		AM			
		PM			
Thursday		AM			
		PM			
Friday		AM			
		PM			

If more than 2 weeks, a second authorization form is required

This log for doses of medication administered by parent

Day	Date	Dose given by Parent		Signature of Staff Verifying
		Time	Next dose due	
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				

RETURNED UNUSED MEDICATION TO PARENT/GUARDIAN

Date	Parent/Guardian Signature	Staff Signature