

Authorization to Give Medication

THIS PAGE TO BE COMPLETED BY PARENT:

Please initial beside the following Medication Administration Safety Checklist Items:

_____ 1. The medication is in the original child resistant container with readable pharmacy or manufacturers label affixed.

_____ 2. Medication is accompanied by information (pharmacy label or written instructions from physician if OTC) indicating child's name, prescribing physician, medication name, dosage, route, times to be given, duration to be given, pharmacy's name and phone number, issue and expiration date.

_____ 3. Medication is not expired.

_____ 4. Administration instructions are filled out completely.

_____ 5. Parents instructions match pharmacy or physician's instructions.

_____ 6. Medication is handed to an adult or placed where it is inaccessible to children.

_____ 7. Medication will be taken home this afternoon.

Child's name: _____

Medication: _____

Dosage: _____ Route: _____

Time(s) to be given: _____ Date(s) to be given: _____

Possible Side Effects: _____

Special Instructions (with food, refrigerate, shake well, before meals, drink water, etc.):

_____ I understand that this medication will be given according to the above directions, and that if any changes occur I must inform the staff and fill out a new form.

_____ Maintenance medication must be updated every 3 Months.

This form expires on: _____ (3 months from today or last date to be given)

Parent's Signature: _____ Date: _____

Signature of Staff who reviewed information with parent: _____

