EVERGREEN
country day

MEDICATION ADMINISTRATION PERMISSION FOR SCHOOL & CHILD CARE

1036 EL RANCHO ROAD | EVERGREEN, CO 80439
303.674.3400 | FAX: 303.670.7957

The parent/guardian of _____ **ask that school/child care staff give the**
(child's name)

following medication _____ **at** _____ **to my**
(name of medicine and dosage) **(time)**

child, according to the Health Care Provider's signed instructions on the lower part of this form.

PRESCRIPTION MEDICATIONS must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.

OVER THE COUNTER MEDICATIONS must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the nurse or school staff delegated to administer medication.

_____ _____ _____
Parent/Legal Guardian's Name **Parent/Legal Guardian Signature** **Date**

_____ _____
Work Phone **Home Phone**

Health Care Provider Authorization

Child's Name: _____ **Birthdate:** _____

Medication: _____ **Dosage:** _____ **Route:** _____

To Be Given at the Following Time(s): _____

Special Instructions: _____

Purpose of Medication: _____

Side Effects That Need To Be Reported: _____

Starting Date: _____ **Ending Date:** _____

_____ _____
Signature of Health Care Provider with Prescriptive Authority **License Number**

_____ _____ _____
Print Name of Health Care Provider **Phone** **Fax Number**

For School Use Only: Medication Verification Checklist

Delegating RN Signature: _____ Initials: _____

Delegated Staff Signature: _____ Initials: _____

Delegated Staff Signature: _____ Initials: _____

Initials	
	Parent Signature
	Health Provider Signature
	Checked 5 Rights
	Count and Verify Meds

Initials	
	Med Exp. Date:
	Completed Log

Initials	
	Email/Phone/Fax Nurse
	Notify Staff