Form # 4A

Authorization to Give Medication at School from Provider & Parents

Name of Center____

Today's Date____

Name of medication_____________________________DOB__________

Name of Medication____

Dose__________________________Router______________Time______

Start Date____________________ End Date_________________________

Purpose of Medication_______________________________________

Adverse or Side Effects______________________________________

Special Instructions____

Provider's printed Name______________________________________

Provider's Signature____

Provider's Phone#____________________ FAX#______________________

Parent/Guardian Authorization to Give Medication

_________________________ (Name of center) **Childcare Center has my** permission to

Administer___________________________________(Name of medication) **to my**

Child____________________ **and ending on** ____________ **as prescribed by The provider on the**

reverse side of this form.

All medication must be ii the original pharmacy labeled container including the following information: Names of child, medicine, provider, & date, dose, time, route.

DATES	TIME	MEDS/DOSE/COMMENTS	GIVEN BY

Starting Medication Count　　# of Pills - Date　　Initials

Date	Count	Init.	Date	Count	Init.	Date	Count	Init.	Date	Count	Init.

Developed by N Graham ,RN, May 17, 2002