

## MEDICATION AUTHORITY

I, \_\_\_\_\_ (Name)

Being the parent / guardian of \_\_\_\_\_ (Child's Name)

Ask the staff of Northwest Community Childcare to administer medication as prescribed by my child's doctor.

DOCTOR \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

MEDICATION (name) \_\_\_\_\_ EXPIRY DATE: \_\_\_\_\_

REASON FOR MEDICATION \_\_\_\_\_

DATE and TIME of LAST DOSAGE \_\_\_\_\_

DOSE \_\_\_\_\_ TIME TO BE ADMINISTERED \_\_\_\_\_ AM/PM

METHOD OF ADMINISTRATION \_\_\_\_\_

MY CHILD IS ALLOWED TO SELF ADMINISTER THEIR MEDICATION (please circle): YES / NO

**Note: This information MUST agree with the label.**

From (Date) \_\_\_/\_\_\_/\_\_\_ To (Date) \_\_\_/\_\_\_/\_\_\_

ADMINISTRATION OF MEDICATION BY STAFF					
Date	Time	Dose	Manner of Administration	Name & Sign of Administer	Name & Sign of Witness

Signature of Parent / Guardian \_\_\_\_\_ Date \_\_\_\_\_

Signature of Responsible person \_\_\_\_\_ Date \_\_\_\_\_

Signature of Nominated supervisor \_\_\_\_\_ Date \_\_\_\_\_

**This authority expires as dated above.**

