JACK & JILL
EARLY CHILDHOOD LEARNING

PRESCRIPTION MEDICATION AUTHORIZATION

TO BE COMPLETED BY PARENT

Child's Name _____ **Date of Birth** (mm/dd/yyyy) _____

Program Name Jack & Jill Early Childhood Learning **Today's Date** (mm/dd/yyyy) _____

To administer a prescription medication:

- The medication must be in its original container, with a legible label from the pharmacy indicating the child's name, date (covers period when medication is to be given), name of medication, dosage, instructions for use (is consistent with parent's request) doctor's/nurse practitioners name, pharmacy name and telephone number.
- Samples must be accompanied by a doctor's written prescription.
- Medications are to be given only to the child indicated on the label (twins and siblings cannot share).
- A separate authorization is required for each medication and each episode of illness.
- Label constitutes the physician/nurse practitioner's order.
- Parent/guardian is to give as many doses as possible at home.

Medication: _____ **Start Date:** _____ **End Date:** _____

Reason for giving: _____

Dosage: _____ **Time(s) to be given at child care:** _____ **AM,** _____ **PM**

Last dose was given at: _____ ☐ AM ☐ PM **on date** _____

Route: ☐ **by mouth** ☐ **skin (location)** _____ ☐ **eye** ☐ Right ☐ Left ☐ **eye** ☐ Right ☐ Left

Possible side effects: _____

Special handling/storage instructions: _____ **Refrigeration** ☐ Yes ☐ No

X PARENT/GUARDIAN SIGNATURE

_____
Signature of Parent/Guardian

X PHYSICIAN/NURSE PRACTITIONER SIGNATURE

_____
Signature of Physician/Nurse Practitioner
(for over-the-counter medication requiring medical consent, otherwise the pharmacy label indicates physician's permission)

The parties agree that this agreement may be electronically signed. The parties agree that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Child care provider must record for each dose

Day	Date	Time	Dosage	Safety Check	Initials
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					

Keep this form in the child's file when medication is completed.

Corresponding Signatures: X _____

X _____ X _____

Unused medication:

☐ Return to parent **or,** ☐ discard appropriately

by: _____ **Date:** _____

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