Meadow Park Preschool and Child Care Center

MEDICATION ADMINISTRATION RECORD – Parental Permission

(A separate authorization is required for each medication)

I, _____ give permission for **Meadow Park Preschool and Child Care Center**
(Parent/Guardian)

to give _____ the following Medication:_____
(Child's First and Last Name)

Amount/Dose:_____ Time of Dose/Frequency:_____
Route of Administration: Oral_____ Topical_____ Inhaled_____ Eye/Nose/Ear_____ Other_____
Start Date:_____ End Date:_____
Date the Prescription was Filled:_____ Prescription Expiration Date:_____
Reason for Medication:_____
Possible Side-effects:_____
Physician's Signature (If over-the-counter medication):_____ Date:_____

Parent's Signature_____ Date:_____

FOR STAFF TO COMPLETE		
Give Medication ONLY if you can answer YES to all of the questions below		
Is the "Medication Administration Record" and "Care Plan" complete?	Yes___	No___
Is the medication in a Ziplock bag labeled with the child's full name/stored in the designated kitchen "Medicine Storage Containers" and out-of-reach of children?	Yes___	No___
Is the original prescription label on the medication container?	Yes___	No___
Is the child's first and last name on the prescription label?	Yes___	No___
Is the date on the medication current?	Yes___	No___

Week_____	Monday		Tuesday		Wednesday		Thursday		Friday	
Dose										
Date										
Time										
Initials										
Comments										
Week_____	Monday		Tuesday		Wednesday		Thursday		Friday	
Dose										
Date										
Time										
Initials										
Comments										
Week_____	Monday		Tuesday		Wednesday		Thursday		Friday	
Dose										
Date										
Time										
Initials										
Comments										

Teacher's Name (Signature & Initials)	Teacher's Name (Signature & Initials)

Used Medication: Date to be returned to the Parent/Guardian_____

Place this form in the child's file when the medication is finished.