



# Medication Administration Packet

Authorization to Give Medicine  
PAGE 1—TO BE COMPLETED BY PARENT/GUARDIAN

## CHILD'S INFORMATION

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Name of Facility/School Today's Date

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Name of Child (First and Last) Date of Birth

Name of Medicine \_\_\_\_\_

Reason medicine is needed during school hours \_\_\_\_\_

Dose \_\_\_\_\_ Route \_\_\_\_\_

Time to give medicine \_\_\_\_\_

Additional instructions \_\_\_\_\_

Date to start medicine \_\_\_\_/\_\_\_\_/\_\_\_\_ Stop date \_\_\_\_/\_\_\_\_/\_\_\_\_

Known side effects of medicine \_\_\_\_\_

Plan of management of side effects \_\_\_\_\_

Child allergies \_\_\_\_\_

## PRESCRIBER'S INFORMATION

\_\_\_\_\_  
Prescribing Health Professional's Name

\_\_\_\_\_  
Phone Number

## PERMISSION TO GIVE MEDICINE

I hereby give permission for the facility/school to administer medicine as prescribed above. **I also give permission for the caregiver/teacher to contact the prescribing health professional about the administration of this medicine. I have administered at least one dose of medicine to my child without adverse effects.**

\_\_\_\_\_  
Parent or Guardian Name (Print)

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Address

\_\_\_\_\_  
Home Phone Number

\_\_\_\_\_  
Work Phone Number

\_\_\_\_\_  
Cell Phone Number

**Receiving Medication**  
PAGE 2—TO BE COMPLETED BY CAREGIVER/TEACHER

Name of child \_\_\_\_\_

Name of medicine \_\_\_\_\_

Date medicine was received \_\_\_\_/\_\_\_\_/\_\_\_\_

**Safety Check**

- 1. Child-resistant container.
- 2. Original prescription or manufacturer’s label with the name and strength of the medicine.
- 3. Name of child on container is correct (first and last names).
- 4. Current date on prescription/expiration label covers period when medicine is to be given.
- 5. Name and phone number of licensed health care professional who ordered medicine is on container or on file.
- 6. Copy of Child Health Record is on file.
- 7. Instructions are clear for dose, route, and time to give medicine.
- 8. Instructions are clear for storage (eg, temperature) and medicine has been safely stored.
- 9. Child has had a previous trial dose.

Y  N  10. Is this a controlled substance? If yes, special storage and log may be needed.

\_\_\_\_\_  
Caregiver/Teacher Name (Print)

\_\_\_\_\_  
Caregiver/Teacher Signature



## Medication Log

PAGE 3—TO BE COMPLETED BY CAREGIVER/TEACHER

Name of child \_\_\_\_\_ Weight of child \_\_\_\_\_

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM _____	AM _____	AM _____	AM _____	AM _____
	PM _____	PM _____	PM _____	PM _____	PM _____
Dosage/amount					
Route					
Staff signature					

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM _____	AM _____	AM _____	AM _____	AM _____
	PM _____	PM _____	PM _____	PM _____	PM _____
Dosage/amount					
Route					
Staff signature					

*Describe error/problem in detail in a Medical Incident Form. Observations can be noted here.*

Date/time	Error/problem/reaction to medication	Action taken	Name of parent/guardian notified and time/date	Caregiver/teacher signature

<b>RETURNED</b> to parent/guardian	Date	Parent/guardian signature	Caregiver/teacher signature
	/ /		
<b>DISPOSED</b> of medicine	Date	Caregiver/teacher signature	Witness signature
	/ /		

**Medication Incident Report**

Date of report \_\_\_\_\_ School/center \_\_\_\_\_

Name of person completing this report \_\_\_\_\_

Signature of person completing this report \_\_\_\_\_

Child's name \_\_\_\_\_

Date of birth \_\_\_\_\_ Classroom/grade \_\_\_\_\_

Date incident occurred \_\_\_\_\_ Time noted \_\_\_\_\_

Person administering medication \_\_\_\_\_

Prescribing health care provider \_\_\_\_\_

Name of medication \_\_\_\_\_

Dose \_\_\_\_\_ Scheduled time \_\_\_\_\_

Describe the incident and how it occurred (wrong child, medication, dose, time, or route?)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Action taken/intervention \_\_\_\_\_

Parent/guardian notified? Yes \_\_\_\_\_ No \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Name of the parent/guardian that was notified \_\_\_\_\_

Follow-up and outcome \_\_\_\_\_

Administrator's signature \_\_\_\_\_

Adapted with permission from Healthy Child Care Colorado.



## Preparing to Give Medication

This is a checklist to use at your child care facility/school to make sure that your program is ready to give medication.

### 1. Paperwork

- Parent authorization to give medications is signed.
- Health care professional authorization or instructions are on file.
- Child Health Record is on file.

### 2. Medication checked when received

- Properly labeled.
- Proper container.
- Stored correctly.
- Instructions are clear.
- Disposal plan is developed.

### 3. Administering medication

- Area is clean and quiet.
- Staff is trained.
- Hands are washed.
- The 5 rights are followed—right child, medication, dose, time, and route.
- Child is observed for side effects.

### 4. Documentation

- Medication log is completed fully and in ink.

Documents in Appendix AA adopted with permission from the NC Division of Child Development to the Department of Maternal and Child Health at the University of North Carolina at Chapel Hill, American Academy of Pediatrics, Connecticut Department of Public, Healthy Child Care Pennsylvania and Healthy Child Care Colorado, 2011.