Medication Administration Record
Page 1 of 2 (must copy back to back)

Authorization For Parent to Complete

(A separate authorization is required for each medication)

I, _____, give permission for _____
Parent Child Care Center

To give _____the following medication:
Full First and Last Name of Child

Medication: _____ Prescription # (if applicable) _____

Amount/Dose: _____

Time of Dose/Frequency: _____

Route of administration: Oral Rectal Topical Inhaled Eye/Nose/Ear Other:_____

Start Date: _____ End Date: _____

Possible Side Effects: _____

Physician Signature : _____Date: _____

(Physician Signature not required on prescription medications affixed with prescription label)

Parents Signature: _____Date: _____
Parent Signature Required

For Staff to Complete

(Give medicine only if you can answer yes to all questions below)

Is the Medication Administration Authorization Complete?	Yes	No
Is the medication in a child-resistant container?	Yes	No
Is the original prescription label on the medication container? (if applicable)	Yes	No
Is the prescription current? (if applicable)	Yes	No
Is today's date before the expiration date?	Yes	No
Is the child's first and last name on the container?	Yes	No

The 6 rights of Medication Administration must be checked every time:

1. Right Child	3. Right Dose	5. Right Route
2. Right Medication	4. Right Time	6. Right Documentation

- Unused medication: Date returned to parents: _____Signature: _____
- This form must be placed in child's file when medication is finished.
- See Page 2 to document Medication Administration (page 2 must be copied back to back with page 1)

Teacher's Printed Name	Teacher's Printed Name

Medication Administration Record

Page 2 of 2 (must copy back to back)

Date	Dose	Time	Dispensed By (signature to match teachers name on front side)	Comments

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