

University Baptist Church
Mother's Day Out
Authorization for Administration of Medication

Medication shall not be administered to any child if not prescribed or recommended by a licensed health care provider (physician, dentist, nurse practitioner).

Child's Name _____ Medication Name _____

Parent's Emergency Numbers _____

Date Medication Filled _____ Medication Expiration Date _____

Physician's Name _____ Office Number _____

Address _____ Emergency Number _____

Pharmacist's Name _____ Address _____

Name of Pharmacy _____ Office Number _____

Frequency and Time Medication is to be Administered _____

If "as needed", a clear explanation is required _____

Route and Dosage of Medication _____

Directions for Storage _____

Directions for Disposal (Please check one of the following)

_____ Send Home _____ Destroy and Dispose of in Appropriate Container

Please attach a written statement of desired effects, side effects and specific instructions. Medication must be brought into the center by a parent and must be kept in the original container. Please attach written instructions received from physician. In order for this center to administer the medication fore mentioned, please sign below.

Parent Signature

Date

Office Use Only

1) Staff Member Adminstrating

Medication: _____

Full Signature

Date _____ Time _____ Dosage _____ Safety Check Complete _____ 45 minute Observation _____
Initial Initial

2)) Staff Member Adminstrating

Medication: _____

Full Signature

Date _____ Time _____ Dosage _____ Safety Check Complete _____ 45 minute Observation _____
Initial Initial

3) Staff Member Adminstrating

Medication: _____

Full Signature

Date _____ Time _____ Dosage _____ Safety Check Complete _____ 45 minute Observation _____
Initial Initial