PRESCRIPTION MEDICATION RECORD

(This record must be maintained in the child's file when completed)

I hereby authorize ***Children's House, Inc.*** to administer the following medication to my child _____. **Child's Date of Birth:** _____

Diagnosis/Allergy Requiring Medication: _____
Side Effects (Staff Should Be Aware Of): _____
Is child currently taking any other medications? _____
If yes, what?_____

Name of MEDICATION: _____
Child must not have first dose of medication at center in case of allergic reaction.
All medication should be accompanied by a labeled dosing cup, syringe or medication spoon.
Has child had this medication before? _____

Dosage - Strength: _____ **Amount:** ___ _____
Route (circle one): **by mouth** **topically** **other:** _____
All medication should be accompanied by a labeled dosing cup, syringe or medication spoon.
Does medication need refrigeration or other special handling? _____

Is this is an EMERGENCY MEDICATION (i.e. EpiPen, etc.) that has not been previously administered? _____ If so, parent signature allows staff to administer in a medical emergency.

Date(s) in which medication is to be given at center _____
Time(s) in which medication is to be given **(must be specific)** _____

I give consent for this information to be clarified/verified by the pharmacy and/or pediatric office.

Parent's Signature: _____**Date:** _____

For Staff Use Only
- ☐ The Medication Consent form has been completed.
- ☐ The medication is in a safety cap container.
- ☐ The original prescription label is on the medication container.
- ☐ The name of the child above is on the container. The child being given the medication is clearly identified.
- ☐ The medication is not expired.
- ☐ The dose, name of drug, route and frequency of administration given on the label is consistent with parental instructions given above.

Received by (Staff Member): _____ **Date:** _____

☐ **Staff who will administer medication is trained in the *Administration of Medication***

Medication can be administered ONLY if ALL items above are checked and/or completed.

Staff member is required to make notation of missed or refused doses.

Date	Time last dose given / Time admin at center	Medication	Dose / Route	Staff Signature	Witness Initial
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Date	Time	Medication	Dose	Staff Signature	Witness Initial

