MEDICATION PERMISSION FORM

***** If the medication is a prescription medication we NEED Health Care provider AND Parent/Guardian signature before bringing it to the center. If the medication is over- the-counter (OTC) we need Parent/Guardian signature before use. *****

Center: _____

Child name: _____ **DOB:** _____

To be completed by Health Care Provider for prescription medications.

Medication: _____ Route: _____

Dosage: _____ time to be given at center: _____

Reason for medication: _____

Possible side effects: _____

Provider name: _____

Provider signature: _____ **Date:** _____

To be completed by Parent/Guardian

I hereby give my permission for _____ to take the above prescription or over-the counter- medication at Head Start Childcare Center as ordered. I understand it is my responsibility to provide such mediation.

Parent/Guardian signature: _____ **Date:** _____

Delegating RN signature: _____ **Date:** _____

- **Prescription medicine: is to be brought to the center in original pharmacy container, with intact pharmacy label and a copy of the medication authorization order. Medication will not be administered unless prescribed by a person with prescriptive authority.**
- **Over-the-counter medicine: is to be brought to the center in original/untampered packaging with the child's name.**