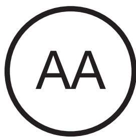

Medication Administration Packet

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 ________ PM ________	AM ________ PM ________	AM ________ PM ________	AM ________ PM ________	AM ________ PM ________
Dosage/amount					
Route					
Staff signature					

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM ________ PM ________	AM ________ PM ________	AM ________ PM ________	AM ________ PM ________	AM ________ 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

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

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.