**AUTHORIZATION FOR ADMINISTRATION OF MEDICATION**

**MEDICATION TYPE:** ❒**PRESCRIPTION** ❒**NON-PRESCRIPTION** ❒**TOPICAL OINTMENT**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **Prescription Medications:** must have a current pharmacist’s label that includes the child’s full name, dosage, current date, times to be administered, and the name and telephone number of the physician.
* **Non-prescription Children’s Medication:** CAN NOT be administered without written authorization from the child’s medical provider. This includes all non-prescription topical ointments.
* **As Needed Children’s Medications:** require written authorization from the child’s medical provider for a period not to exceed ***six months***. Authorization must list the reason, dosage, start date and end date.
* **Medications for Chronic Illnesses**: require a written order from the child’s medical provider for a period not to exceed ***one year***.

**Note:** Products containing Benzocaine, the main ingredient in over-the-counter (OTC) gels and liquids applied to the gums or mouth to reduce pain, may only be applied with authorization from the child’s medical provider for a period not to exceed ***seven consecutive days***.

**Note:** All medications must be provided in the original container, labeled with the child’s full name and any medication spoon/device to administer the medication must be provided. Non prescription medications must be designated for use for children.

I hereby authorize Nest Child Care and Parent Institute agents to administer the following medication to my child. I further agree to indemnify and hold harmless Nest Child Care and Parent Institute, and their agents and servants, against all claims as a result of any and all acts performed under this authority and according to the instructions below.

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| Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Administration Route: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reason for Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Medication Storage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Six Rights of Medication**  **1. Verification that the *right* child receives**  **2. The *right* medication 3. In the *right* dose 4. At the *right* time 5. By the *right* method 6. *And the right* documentation is completed** |

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| Side Effects: | | | | |
| Dosage: | | | | |
| Times of Administration: | Times of Administration: | Times of Administration: | | Times of Administration: |
| Start Date: | | End Date: | | |
| Physician’s Name: | | Physician’s Number: | | |
| Physician’s Signature: | | | | |
| Parent/Guardian Signature: | | | Date: | |