MEDICAL INFORMATION- complete as necessary

Zip and Pep Playcare
MEDICATION ADMINISTRATION FORM

Name of Child ________________________________ Date of Birth ____/____/____

Today's Date ____/____/____ Medication Name________________________________

RX Number (if applicable) __________________________ Controlled Drug? ___ YES ___ NO

Dosage ____ Route ______________________

Time(s) of Administration____

Specific Instructions for Medication Administration

____

Relevant Side Effects of Medication ____

Plan of Management for Side Effects ____

Medication Administration *limit of 2 week authorization unless signed by physician*

Start Date ____/____/____ Stop Date ____/____/____

☐ *Check if there is no stop date to medication. Requires prescribing physician's signature.

☐ *Check if medication is a self- administered, non- emergency injection (i.e. insulin) Requires prescribing physician's signature.

Physician's Signature ______________________________ Date _____________

(For Prescribed or Long- Term Medications Only)

Prescribing Physician's Name ______________________ Phone Number (_____)____________

Pharmacy Name ______________________________ Phone Number (_____)____________

Parent/Guardian Authorization:

☐ I request that medication be administered to my child as described and directed above and attest that I have administered at least one dose of the medication to my child without adverse effects.

Parent/Guardian Authorizing Administration of Medication:

______________________________ ______________________________

Print Name Signature

Relationship to Child: __Mother __Father __Guardian/Other explain:____________

Personnel Receiving Written Authorization and Medication:

______________________________ ______________________________

Print Name Signature

Title/Position ________________________ Date ______________________