

**Parent Permission to Administer Medication**

Child Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List the Name(s) of the Medications to be administered:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was Medication given at home this morning?

 Yes \_\_\_\_\_\_\_\_ (if yes, time: \_\_\_\_\_\_\_\_\_\_\_) No \_\_\_\_\_\_\_\_\_

Does this Medication need to be refrigerated? Yes \_\_\_\_\_ No \_\_\_\_\_

Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Times to be given: \_\_\_\_\_\_\_\_\_\_\_ am/pm \_\_\_\_\_\_\_\_\_\_ am/pm \_\_\_\_\_\_\_\_\_\_ am/pm

Name of Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give CYEC authorization to dispense the Medication.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* This Authorization is good for this week only (Monday – Friday).
* Each week will require a new authorization form.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **MONDAY** | **TUESDAY** | **WEDNESDAY** | **THURSDAY** | **FRIDAY** |
| **Date:** | **Date:** | **Date:** | **Date:** | **Date:** |
| **Time:** |  |  |  |  |
| **Initial:** |  |  |  |  |
| **Time:** |  |  |  |  |
| **Initial:** |  |  |  |  |
| **Time:** |  |  |  |  |
| **Initial:** |  |  |  |  |
| **Time:** |  |  |  |  |
| **Initial:** |  |  |  |  |

* Staff will need to write First Initial and Full Last Name for Verification.
* Medication will be returned after two days of non-usage.

Any unused medication has been returned.

Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_