

AUTHORIZATION TO ADMINISTER PRESCRIPTION AND NON PRESCRIPTION MEDICATION

IN ACCORDANCE WITH HE C 4002.18, THIS FORM MUST BE COMPLETED PRIOR TO THE ADMINISTRATION OF ANY PRESCRIPTION OR NON-PRESCRIPTION MEDICATION.

PRESCRIPTION MEDICATION WILL BE ADMINISTERED IN ACCORDANCE WITH THE PRINTED PRESCRIPTION LABEL, WHICH MUST BE ATTACHED TO THE ORIGINAL PRESCRIPTION CONTAINER.

NON-PRESCRIPTION MEDICATION MUST BE IN ORIGINAL CONTAINER, AND WILL BE ADMINISTERED IN ACCORDANCE WITH THE MANUFACTURER'S PRINTED INSTRUCTIONS. IF THERE ARE NO MANUFACTURER'S PRINTED INSTRUCTIONS FOR THE AGE OF THE CHILD, THE PROGRAM MAY ADMINISTER THE NON-PRESCRIPTION MEDICATION IN ACCORDANCE WITH THE WRITTEN, DATED AND SIGNED INSTRUCTIONS FROM THE CHILD'S PARENT, INCLUDING A STATEMENT THAT THE INSTRUCTIONS HAVE BEEN REVIEWED/APPROVED BY THE CHILD'S LICENSED HEALTH PRACTITIONER, OR WITH SIGNED, DATED WRITTEN INSTRUCTIONS FROM CHILD'S LICENSED HEALTH PRACTITIONER.

PARENT'S AUTHORIZATION

UNH - Child Study and Development Center

I AUTHORIZE CHILD CARE PERSONNEL AT _____ TO ADMINISTER THE

 NAME OF CHILD CARE PROGRAM

FOLLOWING MEDICATION TO MY CHILD: _____

 CHILD'S NAME DATE OF BIRTH

NAME OF MEDICATION	DOSAGE	TIMES TO ADMINISTER	BEGINNING DATE	ENDING DATE
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

PRINTED NAME AND PHONE NUMBER OF CHILD'S LICENSED HEALTH PRACTITIONER _____

PARENT/GUARDIAN'S SIGNATURE _____ DATE SIGNED _____

SPECIAL INSTRUCTIONS FOR ADMINISTRATION OF NON-PRESCRIPTION MEDICATION:

THE ABOVE SPECIAL INSTRUCTIONS WERE: REVIEWED AND APPROVED BY THE ABOVE NAMED LICENSED HEALTH PRACTITIONER
 COMPLETED BY THE LICENSED HEALTH PRACTITIONER WHO'S SIGNATURE IS BELOW

LICENSED HEALTH PRACTITIONER'S SIGNATURE _____ DATE SIGNED _____

CHILD CARE PROGRAM RECORD OF MEDICATION ADMINISTRATION

(TO BE COMPLETED BY CHILD CARE PERSONNEL FOR ALL MEDICATION ADMINISTERED)

NAME OF MEDICATION	AMOUNT	TIME	DATE	INITIALS

NAME OF MEDICATION	AMOUNT	TIME	DATE	INITIALS

NAME OF MEDICATION	AMOUNT	TIME	DATE	INITIALS

NAME OF MEDICATION	AMOUNT	TIME	DATE	INITIALS

SIGNATURE AND POSITION TITLE OF PERSON SUPERVISING ADMINISTRATION/CONTROL OF MEDICATION _____

DATE SIGNED _____