



MEDICATION AUTHORIZATION FORM

CHILD'S NAME: _____ DATE OF BIRTH: _____

CLASSROOM/TEACHER: _____

MEDICATION NAME _____

REASON FOR MEDICATION: _____

IS THIS MEDICATION:

PRESCRIPTION OVER-THE-COUNTER

DOSAGE TO BE GIVEN: _____

TIME(S) TO BE ADMINISTERED: _____

METHOD (ORAL, TOPICAL, INHALED, (CIRCLE ONE)

START DATE: _____ END DATE: _____

SPECIAL INSTRUCTIONS:



I AUTHORIZE LIGHTHOUSE KIDS CHILD DEVELOPMENT CENTER STAFF TO ADMINISTER THE MEDICATION LISTED ABOVE TO MY CHILD IN ACCORDANCE WITH ALABAMA DEPARTMENT OF HUMAN RESOURCES (DHR) CHILD CARE LICENSING REGULATIONS AND THE CENTER'S MEDICATION POLICY.

FURTHERMORE, I UNDERSTAND AND AGREE THAT:

- ALL MEDICATION MUST BE PROVIDED IN THE ORIGINAL CONTAINER
• PRESCRIPTION MEDICATION MUST INCLUDE A CURRENT PHARMACY LABEL WITH THE CHILD'S NAME, MEDICATION NAME, DOSAGE, ROUTE, FREQUENCY, AND PRESCRIBING PHYSICIAN.
• OVER-THE-COUNTER MEDICATION MUST BE LISTED ON THIS FORM
• MEDICATION WILL BE ADMINISTERED ONLY BY DESIGNATED, TRAINED STAFF
• MEDICATION WILL NOT BE ADMINISTERED BEYOND THE DATES AUTHORIZED ON THIS FORM.
• ANY CHANGES TO DOSAGE OR INSTRUCTIONS REQUIRE A NEW FORM
• I AM RESPONSIBLE FOR RETRIEVING ANY UNUSED MEDICATION BY THE END DATE OR WHEN TREATMENT IS DISCONTINUED.

I RELEASE LIGHTHOUSE KIDS CHILD DEVELOPMENT CENTER AND ITS EMPLOYEES FROM LIABILITY FOR ADMINISTERING MEDICATION IN ACCORDANCE WITH THIS AUTHORIZATION AND ALABAMA DHR REGULATIONS.

PARENT/GUARDIAN NAME (PRINT): _____

SIGNATURE: _____ DATE: _____

CENTER USE ONLY

MEDICATION RECEIVED BY: _____

DATE RECEIVED: _____ EXPIRATION DATE CHECKED: YES NO

MEDICATION STORED: REFRIGERATED / OFFICE

MEDICATION DOSAGE LOG-SEE REVERSE