



# Authorization to Dispense Medication

Informal Health and Safety Standards INF-I (1) & (2)

Except for first aid, personnel shall not hand out prescription or nonprescription medications to a child without specific written authorization from the child's physician or parent. All medications shall be stored in accordance with the prescription or label instructions and kept in places that are inaccessible to children. Each dose of medication given to a child shall be documented showing the child's name, name of medication, date and time given, and the name of the person giving the medication.

\*It is up to the provider to decide whether or not they dispense non-prescription medication.

|  |              |               |              |              |
|--|--------------|---------------|--------------|--------------|
| Child's Full Name:                                   |              |               |              |              |
| Name of Medication:                                  |              |               |              |              |
| Prescription Number:                                 |              |               |              |              |
| Physician's Name:                                    |              | Phone Number: |              |              |
| Date(s) to give medication:                          |              |               |              |              |
| Time of day medication is to be given:               | a.m. or p.m. | a.m. or p.m.  | a.m. or p.m. | a.m. or p.m. |
| Amount (Dosage) of medication to be given each time: |              |               |              |              |
| How medication is to be stored:                      |              |               |              |              |

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

## Medication Record to be completed by Child Care Provider

| Date | Time (a.m./p.m.) | Amount (Dosage) | Any Adverse Reaction | Signature of person giving medication |
|------|------------------|-----------------|----------------------|---------------------------------------|
|      |                  |                 |                      |                                       |
|      |                  |                 |                      |                                       |
|      |                  |                 |                      |                                       |
|      |                  |                 |                      |                                       |
|      |                  |                 |                      |                                       |

If adverse reaction to medication was noted, please describe action taken:

\_\_\_\_\_  
\_\_\_\_\_

**Note: This form must be used for all over the counter medications (e.g., Tylenol, cough syrup, Benadryl) and all prescription medications including the use of a Nebulizer.**