Sunflower Montessori and Day Care

Medication Authorization Form

(A separate authorization is required for each medication)

Child's Name: Room:

Medication: _____Dose: _____Time:_____

Frequency:_____ Start Date: _____ End Date: _____

Route of Administration: □ Oral □Topical □Inhaled □Eye/Ear/Nose □Other_____

Reason for Medication:_____ Possible Side Effects:_____

Physician's Signature: _____ Date:_____

Clinic Address:_____ Phone:_____

I_____ give permission for Sunflower Montessori and Day Care
Parent

To give _____ the above Medication.
Your child's first and last name

Parent's Signature: _____ Date:_____

For Staff to Complete

Give medicine **only** if you can answer **yes** to all questions below.

Is the medication Administration Record Complete?	□Yes	□No
Is the medication in a child-resistant container?	□Yes	□No
Is the Original Label/prescription label on the medication container?	□Yes	□No
Is the Prescription current?	□Yes	□No
Is today the date before the expiration date?	□Yes	□No
Is the child's First and Last name on the container?	□Yes	□No

	Monday		Tuesday		Wednesday		Thursday		Friday	
Dose										
Date										
Time										
Teacher's Name										
T-Signature										
Comments										

	Monday		Tuesday		Wednesday		Thursday		Friday	
Dose										
Date										
Time										
Teacher's Name										
T-Signature										
Comments										

Unused Medication return date to parents: _____

Place this form in the Child's file when administration of medication is done.