Community Colleges of Spokane

Spokane County Head Start /ECEAP/EHS
MEDICATION ADMINISTRATION AUTHORIZATION

Child's Last name _____ First _____ M.I. _____ Birthdate _____

THIS SECTION TO BE COMPLETED BY LICENSED HEALTH PROFESSIONAL WITH PRESCRIPTIVE AUTHORITY

Name of Medication	Dosage	Methods of Administration	Time of day to be administered

Diagnosis _____

If given "as needed" (prn), specify the length of time between doses _____

Possible side effects of medication _____

Emergency procedure in case of serious side effects _____

I request and authorize that the above named student be administered the above identified oral medication in accordance with the instructions indicated above from _____ to _____ (not to exceed current school year), as there exists a ***valid health reason which makes administration of the medication advisable during Head Start, Early Head Start and/or child care hours****.*

Licensed health professional's signature _____ Date of signature _____

Telephone number _____ FAX number _____

Print name _____

THIS SECTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I have reviewed the parent information regarding medication at school and request/authorize the school to administer medication to my child in accordance with the LHP's instructions for the period from _____ to _____ (not to exceed current school year). HS/E/EHS Policy CHS 1.6 No 6 c, states that due to special circumstances, it is possible for a dosage(s) to be delayed or missed.

Parent/guardian signature _____ Date of signature _____

Home phone number _____ Work/cell phone number _____

MEDICATION ADMINISTRATION RECORD

Child _____ RM#Option _____ Name of medication _____

Initial amount supplied _____ Medication Expiration date _____ Date Medication Received _____

DATE	TIME	DOSE GIVEN	STAFF INITIALS	AMOUNT REMAINING	COMMENTS

Staff signatures/initials _____ Staff signatures/initials _____

Staff signatures/initials _____ Staff signatures/initials _____