

The following form(s) can be filled in on-line, then printed for signatures and mailing or faxing.

To begin filling out the forms in Acrobat Reader, make sure the **hand** tool is selected then click on a line or in a box and begin typing. Check boxes can be clicked on or off.



Spokane County Head Start/ECEAP/EHS

# MEDICATION ADMINISTRATION AUTHORIZATION

Child's name \_\_\_\_\_

Birth date \_\_\_\_\_

**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 \_\_\_\_\_

