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 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 ___________________________________