Tender Spirits Childcare

Licensed Family Daycare

REQUEST FOR ADMINISTRATION OF MEDICATION

MEDICATIONS:

If your child is prescribed medications ask for a prescription that can be given every 12 or 24 hours by you. I prefer not to administer any medication, as a safety precaution. In the event that a 12 or 24 hour medication cannot be prescribed arrangements for me to administer them can be made. No child will be given any medication, prescription or over the counter, unless **written permission** is given by the parent. Prescription medication shall have the child's name, name of medication, Doctor's name, name of pharmacy, prescription number, date, and directions for administering (prescription label). **The medication must be in the original container as dispensed by the pharmacy**. Administration of any medication will be logged below. **Exception:** As your childcare provider, I will administer Syrup of Ipecac if instructed to do so by poison control or emergency medical services. I reserve the right to decline administering the medication if I am not comfortable with it for any reason.

TO BE COMPLETED BY THE PARENT:

Childs Full Name: _____ Birthdate _____
Parents Full Name: _____
Home Phone#: _____ Work Phone #: _____
Physicians Name: _____ Phone #: _____
Pharmacy Name: _____ Phone #: _____

Name of Medication: _____ Expiry Date: _____
This medication is prescribed to be given as directed - dosage: (example: Give 4 mL every 8 hours for 14 days. Give with food.)
_____
Medication is to be given in the form of: (check one) Pills ___, Drops ___, Tsp. ____, mL ___, **you must supply the dispensing syringe for liquid medications.
Additional Comments (possible reactions consequences or missing medication etc.)
_____
_____
_____
Condition which make this medication necessary:
_____
_____
_____

I request the Caregiver, Monica Andersen, at Tender Spirits Childcare to give medication as prescribed below to my child whose name is recorded above.

I will notify the Caregiver promptly of any changes in medication(s) ordered.

Signature of Mother/Father: _____ Date: _____

TO BE COMPLETED BY THE CAREGIVER:

Date	Medication	Dose	Time Administered	Comments	Caregiver's Signature

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