

# Shiloh UCC Early Learning Center

## Medication Administration Permission

The parent/guardian of \_\_\_\_\_ ask that the ELC staff give the following  
(Child's Name)  
medication \_\_\_\_\_ at \_\_\_\_\_ to my child according to the Health Care  
(Name of Medication) (Time)  
Provider's signed instructions on the lower part of this form.

This Program agrees to administer medication prescribed by a licensed health care provider. It is the parent/guardian's responsibility to furnish the medication. The parent agrees to pick up expired or unused medication within one week of notification by staff.

Prescription Medications must come in a container labeled with the child's name, name of the medicine, time medicine is to be given, dosage, date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on label.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medicine with the Early Learning Center staff delegated to administer medication.

\_\_\_\_\_  
Parent/Legal Guardian's Name Parent/Legal Guardian's Signature Date

\_\_\_\_\_  
Work Phone Home Phone

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### Health Care Provider Authorization to Administer Medication

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_ Route: \_\_\_\_\_

To be given at the following time(s): \_\_\_\_\_  
(attach separate paper if needed)

Purpose of Medication: \_\_\_\_\_

Side Effects that need to be reported: \_\_\_\_\_

Starting Date: \_\_\_\_\_ Ending Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Health Care Provider with Prescriptive Authority License Number

\_\_\_\_\_  
Phone Number Date

I understand that some Emergency medications, which may include the above-listed medication, might cause my child to suffer an adverse reaction or other serious medical condition. I hereby release, waive, discharge and covenant not to sue the School or their employees, officials, agents or volunteers for any liability for damages, injury or death that may result from ill effects or adverse reactions to this medication.

I authorize this medication to be administered at the School by staff persons or volunteers who are **not** physicians, licensed Registered Nurses (RN's), or Licensed Practical Nurses (LPN's). I understand, acknowledge and approve that the individuals administering the medication do not have any form of medical license and will not perform a medical assessment of my child prior to administering the authorized medication.

Further, I acknowledge that the School bears no responsibility for ensuring the medication is administered and the School or their officials, employees, agents or volunteers may decline to administer the medication. If the School declines to administer the medication, the School will take reasonable steps to notify you that the medication will not be administered.

I HEREBY CERTIFY THAT I HAVE READ THIS DOCUMENT IN FULL AND THAT I HAVE THE LEGAL AUTHORITY TO CONSENT TO THE ADMINISTRATION OF THIS EMERGENCY MEDICATION:

\_\_\_\_\_  
Parent/Legal Guardian's Name

\_\_\_\_\_  
Parent/Legal Guardian's Signature

\_\_\_\_\_  
Date