Medication Authorization Form

FIRST STEPS
CHILDCARE & PRESCHOOL

Name of Child: ______________________________ D.O.B. __________ Age: ______ Date: __________

Name of Medication: ______________________ Condition Being Treated: ________________________

Dosage: __________ Time/Frequency: ____________ Start Date: __________ Stop Date: __________

Route: ☐ Oral ☐ Topical ☐ Inhaled ☐ Injection ☐ Other

Additional Instructions/Comments: ____

____

Known Side Effects:____

____

FOR PRESCRIPTION MEDICATION

Prescribing Health Care Provider: ____

Phone Number: ____

FOR CONTROLLED SUBSTANCES

Amount of Medication Received: ____

Staff Member Signature: ____

Staff Member Signature: ____

I hereby authorized and give my permission to the personnel at First Steps Inc. to administer the medication named above to my child according to the instructions provided on this form. I release any liability in relation to the administration of this medication. I agree that the provider and/or personnel at First Steps Inc. will not be held liable for any illness or injury to my child resulting from the administration of this medication, and that First Steps Inc. will not be held responsible for the reimbursement of any medical expenses resulting from such action.

I also acknowledge that I, the parent/guardian, have given the first dose of this medication to my child without any allergic or unexpected reactions.

Parent/Guardian printed name: ____________________________________ Date: _______________

Parent/Guardian signature: ____

RETURN OF MEDICATION

Return Date: ________ Number of Controlled Substances Returned: ________

Parent/Guardian Signature: ____

Staff Member Signature: ____

Child's Name: ______________________ Name of Medication: _________________ Parent/Guardian's Phone #: ________________

ALWAYS review the written Parent/Guardian medication instructions and Health Care Provider's medical order (when necessary) prior to **EVERY** administration of medication. Instructions are on the front of this sheet.

7 Rights **MUST** be performed with **EVERY** dose!

Right **CHILD**, Right **MEDICATION**, Right **DOSE**, Right **ROUTE**, Right **TIME**, Right **REASON**, Right **DOCUMENTATION!**

When medication has been discontinued, it **MUST** be returned to the parents!

Date Given	Time Given	Dose Given	Route Given	Comments/Reactions	Staff Signature	Quality Check

CONTROLLED SUBSTANCES				
# On Hand	**# Given**	**# Remain**	**Staff Signature**	**Staff Signature**