KIDDIE ACADEMY®
EDUCATIONAL CHILD CARE

MEDICATION ORDER FORM

Regulations permit child care providers to dispense prescription and non-prescription medications to children in care under certain conditions. The academy must receive prior written permission from the child's parent; written authorization from the child's physician may also be required. If possible, arrange the time of dosage to be when the child is at home. **Fill out a separate form for each prescription or non-prescription drug to be dispensed to the child.**

NON-PRESCRIPTION MEDICATION: A child may receive only one dose of a non-prescription medication each day the child is in care, with the exception of topical medications such as creams and ointments. A licensed health care practitioner must approve the medication and dosage for the child to receive more than one dose during a single day. The non-prescription medication must be provided to the academy in its original packaging with dosage instructions intact.

PRESCRIPTION MEDICATION: Prescription medications must be stored in a container that has been labeled by the pharmacy or physician and which displays the child's name and an expiration date for the medication. The child may receive medication only according to the written instructions of the health care practitioner, as indicated in writing, or the instructions on the medication label and as provided below.

Name of Child:_____

This medication is being dispensed for the following condition(s):_____

MEDICATION	DOSAGE	HOUR GIVEN	DATES TO ADMINISTER	
			START	STOP

Additional Directions:_____

_____

I/We authorize the staff at the Kiddie Academy of _____ to administer the above named medication to my/our child.

Name of Parent (printed):_____

Signature of Parent:_____Date:_____

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PHYSICIAN AUTHORIZATION FOR MEDICATION

TO BE COMPLETED BY HEALTH CARE PRACTITIONER, ONLY IF NECESSARY	
Instructions for more than one dose of a non-prescription medication:	
Instructions for prescription medication, if different from instructions on label:	
Note any side effects of this medication:	
Note any reasons or conditions when this medication should be stopped or not given:	
Signature of Health Care Practitioner:	Date:
Printed or Typed Name of Health Care Practitioner:	Telephone Number:
If this section is not signed by the health care practitioner, oral permission from the health care practitioner is required. Complete the following:	
Name of person receiving approval from health care practitioner:	
Date:	Time:

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MEDICATION ADMINISTRATION LOG

Child's Name:_____

Medicine:_____

Dates to Administer:_____

Date	Time	Amount Given	Medicine Given	Any Symptoms or Comments	Signature of Administrator