Mountain Recreation
ACTIVE | HEALTHY | TOGETHER

MEDICATION ADMINISTRATION

The Parent / Guardian of _____ ask that Mountain Recreation Metropolitan District staff give the following medication _____ at _____ times to my child, according to the health care provider's signed instructions on the lower part of this form. The 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; child's name, name of medicine, time medicine is to be given, dosage, and date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.
OVER THE COUNTER MEDICATIONS: must be labeled with child's name/ Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.
By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the nurse or schools staff delegated to administer medication.

_____ _____ _____
Parent /Legal Guardian Name Parent / Legal Guardian Signature Date

_____ _____
Work Phone Home Phone

Health Care Provider Authorization to Administer Medication in Child Care

Child's Name: _____ DOB: _____

Purpose of Medication: _____

Medication: _____

Start Date: _____ End Date: _____ Dosage: _____ Route: _____

Health Care Provider Printed Name: _____

Special Instructions:

Side effects that need to be reported:

_____ _____
Signature of Health Care Provider w/ Prescriptive Authority License Number

_____ _____
Phone Number Date

PLEASE ASK THE PHARMACIST FOR A SEPARATE MEDICINE BOTTLE TO KEEP AT CHILD CARE