St JOHN'S EPISCOPAL SCHOOL **Early Childhood Center** **Form A**

REQUEST FOR MEDICATION ADMINISTRATION IN CHILD CARE

Name of Child: ______________________ Birth date: ________ Current Weight: ______

Teacher Name: ______________________ Nursery 1yo's 2yo's 3-5yo's **M T W Th F Child Care Days**

PARENT/GUARDIAN REQUEST FOR THE ADMINISTRATION OF MEDICATION PRESCRIPTION AND NONPRESCRIPTION

California Community Care Licensing allows children to receive prescription and nonprescription medication while in child care when all required conditions are met. I request that medication be administered to my child in accordance with our authorized health care provider's written instructions below. I understand that designated non-medical child care/school personnel may assist in carrying out written orders after training by the school nurse. I will notify the child care center immediately and submit new forms when there are changes in medication, dosage, time of administration, and/or the prescribing authorized health care provider. I give permission for the school nurse/child care provider to exchange medication-related information with my child's authorized health care provider. The school nurse may counsel child care personnel regarding the medication and its possible effects. I understand the school nurse is not always available during child care hours of operation.

Parent/Guardian (print name): ______________________ (sig) ______________________ Date: ________

Telephone: (Work): ____________ (Cell): ____________ (Home): ____________ (E mail) ____________

AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR ADMINISTRATION OF MEDICATION

Medication: ______________________ Dose: ______ Route: ______ Time(s): ____________

Reason for Medication (specify clearly for "as needed" medications): ______________________

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Date to **START** Medication: ____/____/____ Date to **STOP** Medication: ____/____/____

For "as needed" medication: Amount of time between doses ________ Maximum number of doses ________ per day

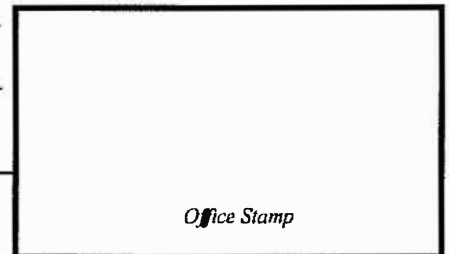
Possible medication reactions: ____

Reactions requiring emergency care (911): ______________________ **Known Allergies:** ____________

Authorized Health Care Provider Signature: ______________________

Authorized Health Care Provider Name (print clearly): ______________________

Office Telephone: ______________________ FAX: ____________



Childcare/ School USE:

Received and reviewed by: ______________________ Date: ____________

Revised 3/2015 *This request is valid for a maximum of 12 months*