Early Learning Essentials

AUTHORIZATION TO ADMINISTER MEDICATION

Child _____ Date of Birth _____

Parent / Guardian _____ Phone # _____

Health Care Provider _____ Phone # _____

For their own safety, any child who needs medication administered while at school will not be allowed to attend class until this form has been signed by a physician and returned to our Administrative Office.

Parent / Guardian Agreement and Approval

- I hereby authorize any person or persons designated by the Early Learning Essentials Health Services Coordinator to administer the following medication(s) to the above-named child.
- I give my permission for exchange of information between Early Learning Essentials and the prescribing health care provider.
- I understand that the medication is to be furnished by me, ***in the original container, labeled by the pharmacy, with the name of the prescribing health care provider, name of the medication, the amount to be taken, and frequency of administration.***
- I understand that in case of serious side effects, Early Learning Essentials staff will follow agency procedures necessary for the well-being of my child.
- I understand that this form must be completed with signatures before any medication will be administered to my child while at the centert and I accept full liability for not providing medication and instructions.

Parent / Guardian Signature _____ **Date** _____

PRESCRIPTION DOSING INSTRUCTIONS

Must be completed by Health Care Professional

Diagnosis / Medical Condition Requiring Medication(s) _____

	Regularly Scheduled Medication	**Emergency Medication**
Medication Name		
Route		
Dosage		
Schedule		
Storage		
Possible Side Effects		
Treatment Period		
Special Instructions		

_____

Name of Health Care Provider

_____ _____

Health Care Provider Signature Date

FOR OFFICE USE ONLY : HSC/NSC REVIEW & ENTRY _____ → HS review & file _____ Teacher Initials _____

Initial & Date Cook Initials if due to SMP _____

Early Learning Essentials

AUTORIZACION PARA LA ADMINISTRACION DE MEDICAMENTOS

Nombre del Niño(a) _____ Fecha de Nacimiento _____

Padre/Tutor _____ # de Teléfono _____

Proveedor de Servicios de Salud _____ # de Teléfono _____

Por su propia seguridad, cualquier niño que necesite tomar algún medicamento en la escuela no se le permitirá asistir a clases hasta que este formulario haya sido firmado por un doctor y entregado a la Oficina Administrativa.

Acuerdo y Aprobación del Padre o Tutor

- Por la presente autorizo a cualquier persona o personas designadas por el coordinador de servicios de salud de Early Learning Essentials para administrar los siguientes medicamentos al niño(a) mencionado en la parte superior de este formulario.
- Doy autorización para el intercambio de información entre Early Learning Essentials y el doctor que receto el medicamento.
- Entiendo que yo debo de proveer el medicamento ***en su envase original, etiquetado por la farmacia, con el nombre del doctor que lo receto, nombre del medicamento, cantidad que se debe administrar y cada cuando debe ser administrado.***
- Yo entiendo que en caso de algún efecto secundario grave, el personal de Early Learning Essentials seguirá los procedimientos de la agencia necesarios para el bienestar de mi hijo(a).
- Yo entiendo que este formulario debe estar firmado antes de que cualquier medicamento sea administrado a mi hijo(a) cuando este en el centro y acepto toda la responsabilidad si no proveo el medicamento e instrucciones.

Firma del Padre o Tutor _____ **Fecha** _____

PRESCRIPTION DOSING INSTRUCTIONS (Instrucciones)

Must be completed by Health Care Professional (Llenado por profesionales medicos)

Diagnosis / Medical Condition Requiring Medication(s) _____

	Regularly Scheduled Medication	Emergency Medication
Medication Name		
Route		
Dosage		
Schedule		
Storage		
Possible Side Effects		
Treatment Period		
Special Instructions		

_____

Name of Health Care Provider

_____ _____

Health Care Provider Signature Date

FOR OFFICE USE ONLY ☐ HSC/NSC REVIEW & ENTRY _____ → _____HS review & file _____Teacher Initials

Initial & Date

_____ Cook Initials if due to SMP