Early Childhood Education

Medication Authorization Form

Child's Picture

Child's Name: _____ **DOB:** _____

TO BE COMPLETED BY HEALTH CARE PROVIDER

1. Name of Medication ☐ **Controlled Substance**	Amount (dosage) to be given (specific)
Route: □ Oral □ Inhaler □ Spacer □ Nebulizer □ Topical □ Rectal □ Nasal □ Injection □ Other _____	Times Medication is to be Given at school
If p.r.n., list symptoms/conditions under which medication is to be given	Minimum time between doses
Side Effects	Date to Begin Giving Medication: Date to Stop Medication:
Reason for medication	Storage of Medication

Health Care Provider Signature Date	Health Care Provider's Address & Phone Number
Health Care Provider Print Name	

TO BE COMPLETED BY PARENT/ LEGAL GUARDIAN

I give permission for (name of child) _____ to receive the above medication(s) at Head Start according to Starfish Family Services Medication Policy. Permission is given for the health care provider/staff and Head Start staff to share information needed to assist my child with medication needs. Head Start requires the parent/ legal guardian to bring medication In the original container with the label from the pharmacy.

Parent/Legal Guardian Signature_____ Print Name _____ Date _____

Phone _____ Cell _____ Work _____

TO BE COMPLETED BY HEAD START STAFF

Date form received _____ Date medication received_____Amount of medication received _____

Staff signature _____Health Specialist reviewed/signature_____