Medication Administration Permission

10A NCAC 09 .0803 (centers) and .1720(b) (family child care homes)

Parent/guardian completes the Medication Administration Permission and must sign and date it. The person accepting this form must attach the Medication Administration Record(s) to this form.

Permission valid from date:	To date:

Only complete this box if the medication is for a child who has a chronic medical condition or an allergy

☐ This document is written permission to administer this medication for up to 6 months.

Specific chronic medical or allergic condition: _____

Child has an ☐ Action Plan ☐ Individualized Health Care Plan

Child's full name:	Date of birth:
Medication Name:	Expiration Date:
Date(s) to give medication:	

When to give medication (choose one):

☐ Give medication at these specific times (list times):

☐ Give medication as-needed (write as-needed criteria below):

List the specific symptoms or circumstances needed to give the medication and how often it can be given.

For example: If Suzy has a rash and is scratching it, apply this ointment to the rash. Wait at least 6 hours before reapplying.

Dosage (how much medication to give):
Route (how to give the medication):
Special instructions on how to give medication:
Possible Reactions or side effects:
☐ Child has received at least one dose of medication at home without reactions or side effects.

Prescribing health care professional name:	Phone:
Pharmacy	Phone:

I give authorization to give medicine and to call the prescribing health care professional or pharmacy if needed

Parent/guardian name:	
Parent/guardian signature:	Date:

Medication received, returned, or disposed of:

Received from Parent/ Guardian	Date	Amount	Parent/Guardian Signature	Child Care Provider Signature
Returned to Parent/Guardian	Date	Amount	Child Care Provider Signature	Witness Signature
Disposed of Medicine	Date	Amount	Child Care Provider Signature	Witness Signature

Medication Administration Record

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Person who gives the child the medicine completes this Medication Administration Record. Copy this page when you need more lines to record medication administration. Attach page to the Medication Administration Permission.

If an error occurs and the child requires medical attention, call 9-1-1 and/or Poison Control immediately.

Child's name:

Medication name:

Date given	Time given	Dose given	Route	Name of person giving medication	Signature of person giving medication	Reaction/side effect, if observed

Date	Time	Error or mishap while giving medication	Parent/guardian notified?	Child care provider signature
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	