KIDS KLUB CHILD DEVELOPMENT CENTER MEDICATION FORM

This specific form must be filled out and turned in along with the child's medication in its original packaging. No other form accepted.

Medication: _____

Child's Name: _____D.O.B.__/___/___ PARENT'S NAME: _____

Parent's Authorization Box (*This entire box must be complete.)*

Reason for Medication:_____ Administration Method (e.g. orally, drops in the ear): _____

Included Administration Device/Equipment (e.g. dropper, dosing cup, nebulizer):_____

Dosage Amount: _____ When to Administer: _____

Administration Instructions: _____

(BE SPECIFIC. WE WILL NOT ACCEPT FORMS THAT HAVE THE WORDS "AS NEEDED.")

Medication Storage Requirements: ❒ Refrigerated ❒ Room Temperature ❒ Other _____

Possible Side Effects and Expected Protocol:_____

I have read the Medication Policy and I hereby authorize Kids Klub Child Development Centers' agents to administer the following medication to my child:

Parent Signature: _____

Physician's Authorization Box (*This entire box must be completed by the Child's Physician.)*

I certify that as long as all above directions (and medications listed) are followed, all requirements can safely be performed by a layperson and do not require training from a licensed professional.

Name of Child: _____ Name of Medication: _____

If dosage is different than what is on the medication label please list all special requirements/circumstances/instructions:

_____

*Physician's Name: _____

*Physician's Phone Number: _____

*Physician's Signature: _____ *Date: _____

Physician Stamp (Required)

Acceptance Date	Medication Expiration Date	Parent Signature	Date Medication Logged out	Staff Signature
__/__/__	__/__/__		__/__/__	
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Date	Medication	Dosage	Time	Parent Notified	Staff Signature
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Kids Klub Authorized Employee

Employee Accepting Medication **Name:** ____________________**Sign:**___________________ **Date:** _____________

Is this form for an inhaler or EpiPen? CIRCLE: YES or **NO (if YES initial below that the correct form is attached)**

If **inhaler**, you must include the **Nebulizer Form** _______ If **EpiPen**, you must include the **FARE Form** ________

Accept Medication only if you can answer "Yes" to all questions below. (Circle "Yes" or "No".)

Authorization Form Complete	**Yes**	**No**	**Medication is not expired**	**Yes**	**No**
Medication in original container	**Yes**	**No**	**Specific Instructions are filled out**	**Yes**	**No**
Medication has original label	**Yes**	**No**	**Administration Device Included (e.g. dropper)**	**Yes**	**No**
Child's name is on the medication	**Yes**	**No**	**Cleaning requirements of Administration Device Reviewed**	**Yes**	**No**
Parent has 'logged-in' medication	**Yes**	**No**			
Physician signed signature statement	**Yes**	**No**	**All lines filled in**	**Yes**	**No**

❒ **Child no longer needs medication. Parent has picked it up.**	**Parent Signature:**	**Staff Signature:**	**Date:**
Parent was called on: ____________ **at** ___________________ **to pick up medication.** ❒ **Destroyed and recorded on the medication destruction log.**			