ADAPTED BY COUNTRYSIDE FROM THE MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES SECTION FOR CHILD CARE REGULATION

MEDICATION AUTHORIZATION

MEDICATION REQUIREMENT

PRESCRIPTION MEDICATION SHALL BE IN THE ORIGINAL CONTAINER AND LABELED WITH THE CHILD'S NAME, INSTRUCTIONS, INCLUDING TIMES AND AMOUNTS FOR DOSAGES, AND THE PHYSICIAN'S NAME. ALL NON-PRESCRIPTION MEDICATION SHALL BE IN THE ORIGINAL CONTAINER AND LABELED BY THE PARENT(S) WITH THE CHILD'S NAME AND INSTRUCTIONS FOR ADMINISTRATION, INCLUDING TIMES AND AMOUNTS FOR DOSAGES. A SEPARATE FORM IS NEEDED FOR EACH MEDICATION. THIS FORM IS VALID ONLY FOR THE DATES INDICATED BELOW.

I AUTHORIZE CHILD CARE PERSONNEL TO ADMINISTER THE FOLLOWING MEDICATION TO MY CHILD:

MEDICATION NAME: _____ EXPIRATION DATE: _____

(PROPER NAME OF MEDICATION-NAME LISTED ON CONTAINER)

CHILD'S FULL NAME	**MEDICATION START DATE**	**MEDICATION END DATE** SPECIFIC DATE - NO MORE THAN 6 MONTHS
EXACT DOSAGE AMOUNT (I.E.-TSP / ML / VIAL / PUFF / PEA SIZE AMOUNT)	**SPECIFIC TIME(S) OF DAY**-CANNOT SAY AS NEEDED UNLESS SYMPTOMS ARE LISTED (I.E. - AS NEEDED FOR ASTHMA SYMPTOMS-WHEEZING/SHORT OF BREATH/EXCESSIVE COUGHING) (I.E. - AS NEEDED FOR ECZEMA-RASH)	
POSSIBLE SIDE EFFECTS		
SIGNATURE OF PARENT(S) OR GUARDIAN		**DATE**

RECORD OF ADMINISTRATION

STAFF NAME	DATE	MEDICATION NAME	DOSAGE	TIME