## **Medication Administration Permission Form**

10A NCAC 09 .0803 (centers) and .17209(b) (family child care homes)

Parent/guardian completes, signs, and dates the Medication Administration Permission Form. The person accepting this form must attach the Medication Administration Record(s) to this form.

Permission valid fro	om 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: $\square$ N	/ledical Action	Plan (required	)					
Child's full name:	f birth:							
Medication name:	tion date:							
When to give medication (choose one):								
☐ Give medication on these specific dates and times:								
☐ Give medication as needed. List the specific symptoms or circumstances needed to give the medication and how								
often it can be give	en. Ex. If Suzy ha	s a rash and is scr	ratching it, apply this ointment to the rash. W	ait at leas	t 6 hours before reapplying.			
Dosage (how much	n medication t	to give):						
Route (how to give	the medicati	on):						
Special instructions	s on how to g	ive medication	):					
Possible reactions or side effects:								
☐ Child has received at least one dose of medication at home without reactions or side effects.								
Prescribing health	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 si	Date:							
Medication received, returned, or disposed of:								
Received from	Date	Amount	Parent/guardian signature	Child care provider signature				
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- Incarcation receiv	redelived, recurried, or disposed on									
Received from	Date	Amount	Parent/guardian signature	Child care provider signature						
parent/guardian										
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**

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

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 (800-222-1222) immediately.

Child's na	ame:							
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			

