Medication Form

Protocol for a child requiring medication storage and/or administration with our facility is as follows:

- For **Prescription Medications**, the child's health care provider must complete and sign in section two below.
- Child must have **previously received a medication with no medical issues** before facility will administer, excluding injectors.
- Medication only accepted in **original labeled container and box** with all labels. Epinephrine injectors MUST have both (2) pens.
- Emergency Medical Action Plans issued by physician must be attached for emergency-use and allergy medications.
- Please only list one child and one medication per form.
- Medication may **NOT** be in the possession of a child and must be stored according to policy.
- Medication will not be administered if expired. It is the parent/guardian responsibility to note that date and provide new medicine.
- **Medication Forms must be renewed annually and/or when the medication expires, whichever occurs first.**

Child Name _____

This medication is: ☐ Prescription from physician/CRNP ☐ "Over the Counter" (non-prescription)

Medication Type (ONE):

☐ Epinephrine Injector

☐ Inhaler

☐ Oral

☐ Topical

Medication Name: _____

Dosage _____ Frequency _____

Expiration Date: _____/_____/_____

First Dose to begin _____/_____/_____

Final Dose _____/_____/_____ *May not surpass expiration date.*

Refrigeration Required: ☐ Yes ☐ No

Instructions for use _____

Is the medication required for your child's allergy? ☐ Yes ☐ No *If Yes, Emergency Medical Action Plan must be attached.*

Type of Allergy: ☐ Food _____ ☐ Environmental _____ ☐ Other _____

Allergens include _____

TO BE COMPLETED BY PRESCRIBING HEALTH CARE PROVIDER FOR PRESCRIPTION MEDICATION

It is my understanding that the employees of a child care/school facility charged with the administration of this treatment/procedure during childcare hours rely on directions contained in this document. I further certify that I am the health care provider who prescribed the treatment, that the child named on this document is under my supervision as a patient, and that the medication, dosage, directions for use, and storage information on this document is accurate for this child and matches the child's Emergency Medical Action Plan (if applicable). **Child's Emergency Medical Action Plan for medication use as issued by his/her physician, if one exists, has been attached to this form.**

PRESCRIBER NAME _____ PRESCRIBER SIGNATURE _____

OFFICE ADDRESS _____

CONTACT PHONE _____ DATE _____

PARENT ACCEPTANCE AND REQUEST FOR MEDICATION STORAGE AND ADMINISTRATION

As the parent/guardian of the above named child, I grant permission to Camp Curiosity, Curiosity Shoppe, and Toddler Center Inc. to administer the medication described on this form to my child as described in treatment instructions.

I agree that my child has been administered the above listed medication by a parent/guardian prior to the parent/guardian's request for administration by Camp Curiosity, Curiosity Shoppe, and Toddler Center Inc. and he/she did not have any bodily reaction as a result of its use.

I agree that the above medication will be provided with all required labels, packaging, and expiration date to be stored on facility campus throughout the duration of my child's attendance and may not be kept in my child's possession.

I hereby request that the medication described above be administered to my child and release and hold harmless Camp Curiosity, Curiosity Shoppe, and Toddler Center Inc. and its employees from liability for any damages my child may suffer as a result of this request.

PARENT NAME _____ PHONE _____

PARENT SIGNATURE _____ DATE _____