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 fr | om date: | | To date: | | |
|--|--------------------|---------------------|---|---------------|----------------------------|
| - | | | tion is for a child who has a chronic n | | ndition or an allergy |
| | • | | nister this medication for up to 6 mon | ths. | |
| Specific chronic me | _ | - | | | |
| Child has an: | Medical Action | Plan (required | l) | | |
| Child's full name: | | | | Date of | birth: |
| Medication name: | | | | Expirati | ion date: |
| When to give med | ication (choo | se one): | | | |
| ☐ Give medication | on these spe | cific dates and | times: | | |
| ☐ Give medication | n as needed. L | ist the specific | symptoms or circumstances needed | l to give tl | he 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. V | /ait at least | 6 hours before reapplying. |
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| | | | | | |
| Dosage (how muc | n medication t | to give): | | | |
| Route (how to give | e the medicati | on): | | | |
| Special instruction | s on how to g | ive medicatior | 1: | | |
| Possible reactions | or side effects | s: | | | |
| ☐ Child has recei | ved at least or | ne dose of med | dication at home without reactions of | r side effe | ects. |
| Prescribing health care professional name: | | | | | Phone: |
| Pharmacy: | | | | | Phone: |
| I give authorizati | on to give me | dicine and to | call the prescribing health care prof | essional | or pharmacy if needed |
| Parent/guardian n | ame: | | | | |
| Parent/guardian signature: | | | | | Date: |
| Medication recei | ved, returned | , or disposed | of: | 1 | |
| Received from | Date | Amount | Parent/guardian signature | Child | d care provider signature |

| Wicalcation receiv | Medication received, retained, or disposed of. | | | | | | | | |
|-----------------------------|--|--------|-------------------------------|-------------------------------|--|--|--|--|--|
| 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 | | |
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| Date | Time | Error | or mishap | while giving medication | Parent/guardian notified? | Child care provider signature | | |
| | | | | | ☐ Yes ☐ No | | | |
| | | | | | ☐ Yes ☐ No | | | |
| | | | | | ☐ Yes ☐ No | | | |

