University of Nebraska–Lincoln Children's Center

Medication Administration Packet

Authorization to Give Medicine
PAGE 1 – TO BE COMPLETED BY GUARDIAN

CHILD'S INFORMATION

University of Nebraska – Lincoln Children's Center ____/____/____
Name of Facility/School Today's Date

____ ____/____/____
Name of Child (First and Last) Date of Birth

Name of Medicine____

Reason medicine is needed during school hours____

Dose____________________ Route (circle one): Oral, Topical, Eye Drops, Ear Drops, Inhalation, or Other:____________________

Time to give medicine____

Additional Instructions____

Date to start medicine ____/____/____ Date to stop medicine ____/____/____

Known side effects of medicine____

Plan of management of side effects____

Child Allergies____

PERMISSION TO GIVE MEDICINE

I hereby give permission and deemed competent the facility/school to administer medicine as prescribed above. **I also give permission for the caregiver/teacher to contact the prescribing health professional about the administration of this medicine. I have administered at least one dose of medicine to my child without adverse effects.**

____
Parent or Guardian Name (Print)

____
Parent or Guardian Signature

____
Address

____
Home Phone Number Work Phone Number Cell Phone Number

Adapted with permission from the NC Division of Child Development of Maternal and Child Health at the University of North Carolina at Chapel Hill, Connecticut Department of Public Health, and Healthy Child Care Pennsylvannia.

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Medication Log

PAGE 2 – TO BE COMPLETED BY GUARDIAN/TEACHER DAILY

Name of child____Weight of Child____________________

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Given last at	AM________ PM________	AM________ PM________	AM________ PM________	AM________ PM________	AM________ PM________
Actual time given	AM________ PM________	AM________ PM________	AM________ PM________	AM________ PM________	AM________ PM________
Dosage/amount					
Route					
Staff Signature					

Describe error/problem in detail in a Medical Incident Form. Observations can be noted here.

Date/time	Error/problem/reaction to medication	Action taken	Name of parent/guardian and time/date	Caregiver/Teacher signature

	Date	Parent/guardian signature	Teacher signature
RETURNED to parent/guardian	/ /		
	Date	**Caregiver/teacher signature**	**Witness signature**
DISPOSED of medicine	/ /		

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Receiving Medication

PAGE 3 – TO BE COMPLETED BY TEACHER EACH TIME MEDS ARE DROPPED OFF IN CLASSROOM

Name of child____

Names of medicine____

Date medicine was received ____/____/____

Safety Check

- ☐ 1. Original Container/Packing
- ☐ 2. Original prescription or manufacturer's label with the name and strength of the medicine.
- ☐ 3. Name of child on container is correct (first and last).
- ☐ 4. Current date on prescription/expiration label covers period when medicine is to be given.
- ☐ 5. Name and phone number of licensed health care professional who ordered medicine is on container or on file.
- ☐ 6. Instructions are clear for dose, route, and time to give medicine.
- ☐ 7. Instructions are clear for storage (eg, temperature) and medicine has been safely stored.
- ☐ 8. Child has had previous trial dose.
- ☐ 9. For PRN medicine (as needed), a doctor's note is attached.

Y☐ N☐ 10. Is this a controlled substance? If yes, special storage and log may be needed.

____
Teacher Name (Print)

____
Teacher Signature

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