MI CASITA HOME CHILD DAY CARE

Medication Authorization Form
(Make as many copies as needed.)

Date: _____

Child's Full Name:
_____

Name of medication:
_____

(Medication must be in the original container labeled with child's full name).
Dose to be given: _____
Time of day: _____
(Provider must administer the medication in amounts according to the label directions or as amended by a physician). (I cannot administer medication after the expiration date). □
If a child has a recurring medical problem, such as headaches, asthma attacks, or allergic reactions, the parent or the child's health-care professional may sign a medication authorization form allowing provider to administer the medication for up to a six-month period. If this is applicable to your child, please check the box. □
Symptoms to watch for:
_____
_____

Competency Statement
I, _____ have determined Eugenia Alexander competent to give or apply medication to my child(ren). I understand that Mi Casita-Home Child Day Care has a responsibility to assess the ability of staff to give or apply medication safely and may give or apply medication to my child(ren).

Parent Signature: _____Date: _____

Provider Signature: _____Date: _____

Provider documentation:

Date: _____

Time Given: _____

Dose: _____

Provider Initial: _____