ELKHART AND ST. JOSEPH COUNTIES HEAD START CONSORTIUM

PARENT PERMISSION FOR MEDICATION ADMINISTRATION

PERMISO DE LOS PADRES PARA ADMINISTRAR MEDICINA

School Year / año escolar _____

Child's Name / Nombre del niño(a) _____

Date of Birth / Fecha de Nacimiento _____

***MUST BE COMPLETED BY PARENT** / Para ser completada por los padres*

I hereby authorize any person or persons designated by the Health Staff to assist my child to take the following medications at school / Yo por este medio autorizo a cualquier persona o personas designados por el Consultante de salud para que ayuden a mi niño(a) a que tome las síguientes medicinas en la escuela.

Reason for medication / Razón por la que toma el medicamento: _____

Name of medication / Nombre del medicamento _____

Name of prescribing physician / Nombre del medico que prescribió el medicamento: _____

Phone / teléfono: _____

Parent / Guardian Signature / Firma del Padre / Madre / Guardián: _____

Date / Fecha: _____

ALL MEDICATION MUST BE BROUGHT TO THE CLASSROOM IN THE ORIGINAL CONTAINER BY AN ADULT / TODOS LOS MEDICAMENTOS SE DEBEN DE TRAER A EL SALÓN DE CLASE EN EL ENVASE ORIGINAL POR UN ADULTO.

***MUST BE COMPLETED BY PHYSICIAN** / Debe Ser compensado por el medico.*

NAME OF MEDICATION/DOSAGE: _____

SPECIAL INSTRUCTIONS: _____

POSSIBLE SIDE EFFECTS TO WATCH FOR: _____

- **Prescription label includes** Child's name; frequency and amount of dosage; name of the drug; duration of administration; method of administration; expiration date; storage instruction; date filled; and name of the prescribing physician.

Physician/Nurse Practitioner Signature:_____ **Date:** ____/____/____

NOTE: A separate flow sheet must be completed for every medication a child is taking during Head Start Classroom hours and the medication must be documented every time it is given.

If you have any questions or concerns, please call our office at (574) 393-5864