NON-PRESCRIPTION MEDICATION RECORD

I hereby authorize ***Children's House, Inc.*** to administer the following medication to my child ______________________________________. **Child's Date of Birth:** _________________

Diagnosis/Allergy Requiring Medication: ____
Side Effects (Staff Should Be Aware Of): ____
Is child currently taking any other medications? __________________________________
If yes, what?____

Name of MEDICATION: ____

Child must not have first dose of medication at center in case of allergic reaction.

Has child had this medication before? ___________________________________
Dosage - Strength: _____________________ **Amount:** ___ ______________________
Route (circle one): **by mouth** **topically** **other:** _______________________

All medication should be accompanied by a labeled dosing cup, syringe or medication spoon.

Does medication need refrigeration or other special handling? __________________

Date(s) in which medication is to be given at center____________________________________
Time(s) in which medication is to be given **(must be specific)** _________________________

I give consent for this information to be clarified/verified by the pharmacy and/or pediatric office.

Parent's Signature: ___________________________________**Date:** _________________

For Staff Use Only

☐ Current Authorization for administering of non-prescription medication has been verified in child's file and is signed by physician and parent/guardian.

Staff Initials

- ☐ The Medication Consent form has been completed.
- ☐ The medication is in a safety cap container.
- ☐ The original label is on the medication container.
- ☐ The name of the child above is on the container. The child being given the medication is clearly identified.
- ☐ The medication is not expired.
- ☐ The dose, name of drug, route and frequency of administration given on the label is consistent with parental instructions given above and information on Authorization to Administer Non-Prescription Medication form.

Received by (Staff Member): _________________________________ **Date:** ____________

☐ **Staff who will administer medication is trained in the *Administration of Medication***

Medication can be administered only if ALL items above are checked and completed.

Staff member is required to make notation of missed or refused doses.

Date	Time last dose given / Time admin at center	Medication	Dose / Route	Staff Signature	Witness Initial
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