**Appendix D: AUTHORIZATION FOR DRUG/MEDICATION ADMINISTRATION**

**Seaforth Cooperative Children’s Centre**

*This form must be completed by the parent of a child who is requesting that a drug or medication be administered during hours that the child receives child care, in accordance with the child care centre’s medication administration policy and procedures.*

**Child’s Full Name:** Click here to enter text.

**Child’s Date of Birth** (dd/mm/yyyy)**:** Click here to enter text.

**Date Authorization Form Completed** (dd/mm/yyyy)**:** Click here to enter text.

**Date Authorization Form Updated** (dd/mm/yyyy)**:** Click here to enter text.

| **Name of Drug or Medication** (as per the original container label): | Click here to enter text. |
| --- | --- |
| **Date of Purchase or Date Dispensed:** (dd/mm/yyyy) | Click here to enter text. |
| **Expiry Date:** (dd/mm/yyyy) | Click here to enter text. |
| **Authorization Start Date:** (dd/mm/yyyy) | Click here to enter text. |
| **Authorization End Date:** (dd/mm/yyyy or ongoing) | Click here to enter text. |

**Method of Medication Administration (initial below)**

[ ]  Child care centre staff are to administer the drug or medication to my child. \_\_\_\_

**Medication Administration Schedule**

[ ]  The drug or medication needs to be administered according to the following schedule:

| **Day(s) of the Week** | **Time(s) of the Day / Intervals** | **Amount/Dosage** | **Additional Information (where applicable)** |
| --- | --- | --- | --- |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

**AND/OR, where drugs are to be administered on an ‘as needed’ basis:**

[ ]  The drug or medication needs to be administered when the following physical symptoms are observed:

Click here to enter text.

Amount/Dosage:

**Parent/Guardian Authorization Statement:**

I hereby authorize the person in charge of drugs or medications at Seaforth Co-operative Children’s Centre to administer the above-named drug or medication to my child and handle the drug or medication in accordance with the procedures I have provided on this form as outlined in the doctor’s written directions for administration..

I understand that expired drugs or medications will **not** be administered to my child at any time in accordance with the child care centre’s medication administration policy.

I understand that staff at Seaforth Co-operative Children’s Centre are not medically trained to administer drugs and medications.

|  |  |
| --- | --- |
| **Print name:** | **Relationship to Child:**Click here to enter text. |
| **Signature:**  | **Date Signed:** (dd/mm/yyyy)Click here to enter text. |

**Received By:**

|  |  |
| --- | --- |
| **Print name:** | **Role at Child Care Centre:**Click here to enter text. |
| **Signature:**  | **Date Signed:** (dd/mm/yyyy)Click here to enter text. |

**For Child Care Centre Use Only**

**Location medication will be stored:**

**For Office Use Only**

**Date Drugs/Medication Returned to Parent / Pharmacy** (dd/mm/yyyy)**:**