Shining Stars Childcare, LLC

Medication Authorization Form

Medical Authorization

I _____ give permission to Shining Stars Childcare, LLC to give my child the below described medication for my child _____. Shining Stars Childcare, LLC agrees to administer the medication listed below as prescribed by a licensed health care provider. I also give permission for my child's health care provider to share information about the administration of the following medication. It is the parent's responsibility to furnish the medication. The parent agrees to pick up expired or unused medication for proper disposal.

Prescribed Medications: must be in the original container labeled with the child's name, name of medication to be given, dosage, date medication is to be stopped.

Over-the-counter Medications: must be in the original container labeled with the child's name.

_____ _____

Parent/Guardian Date

Health care provider authorization to administer medication at Shining Stars Childcare, LLC

Child's Name _____ Birthdate _____

Medication _____ Dosage _____

Route _____ To be given at the following times _____

Special Instructions _____

Purpose of medication _____ Side effects to report _____

Medication start date _____ Medication end date _____

Signature of health care provider with prescriptive authority _____

Printed name _____ Date _____

Please ask the pharmacist for a separate medicine bottle to keep at childcare, thank you.