



Prescription Medication

Parent Authorization (AMC 16.55.370)

I authorize _____ to administer the following
(name of facility)

prescription medication to _____
(child's name)

Name of medication as listed on label	Dosage (must match label's dosage)	Time medication is to be given	Start date	Stop date	Parent initials

Parent's signature: _____ Date: _____

Documentation of Administration of Medication

Date	Time	Dosage	Initials of person administering medication	Comments:

According to AMC 16.55.370 the following requirements apply to the administration of prescription medications. It is not a requirement to complete the following, but highly recommended by the Department.

- | | | | | | |
|--------------------------------|------------------------------|-----------------------------|---|------------------------------|-----------------------------|
| Packaged in original container | <input type="checkbox"/> yes | <input type="checkbox"/> no | Child's name clearly listed on medication | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Clear dosage instructions | <input type="checkbox"/> yes | <input type="checkbox"/> no | Permission matches label directions | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Expiration date checked | <input type="checkbox"/> yes | <input type="checkbox"/> no | Pharmacy label attached | <input type="checkbox"/> yes | <input type="checkbox"/> no |

Staff signature _____ Date _____