



## AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Medication Type:

\_\_\_\_\_ Prescription    \_\_\_\_\_ Non Prescription    \_\_\_\_\_ Topical Ointment

I have read the MEDICATION POLICY located in the Parent Handbook and I hereby authorize Stepping Stone University Preschool's agents/teachers to administer the following medication to my child:

Child's Name \_\_\_\_\_ Date \_\_\_\_\_

I hereby acknowledge Stepping Stone University Preschool only administers EMERGENCY ACTION MEDICATIONS such as: **PRESCRIBED EPIPEN-EPIPEN JR, INHALER, ANTIHISTAMINE, NEBULIZER** AND will re-apply TOPICAL SUNSCREEN/ OINTMENTS as specified in the parent handbook. All other medications will need to be administered by the parent/legal guardian of the child named in this form.

**-Prescription Medications:** Must have a current pharmacist's label that indicates the child's full name, dosage, current date, times to be administered, and the name and telephone number of the physician.

**-Non-Prescription Children's Medications:** must have written authorization from the parent/guardian and written authorization from the child's medical provider if required to continue use beyond three (3) consecutive days.

**-Non- Prescription Children's Topical Ointment** (listed below): Can be applied with authorization from the parent/guardian according to the manufacturer's instructions for a period not to exceed one (1) year. Written authorization from the child's medical provider is required to continue use beyond the three (3) consecutive days or if the child's condition worsens.

**-As Needed Children's Medications:** Require written authorization from the child's medical provider for a period not to exceed six (6) months. Authorization must list the reason, dosage, start date, and end date.

**-Medications for Chronic Illness:** Require a written order from the child's medical provider for a period not to exceed one (1) year. (See Prescription and Non-Prescription medication above for details.)

**\*All items above must be in the original container, clearly labeled, non expired and labeled with the child's name and specific instructions. Medication must have proper spoon/device to administer the medication as provided.**

**\*All medications and topical ointments/ items must be supplied by the parent. As per the Parent Handbook you also acknowledge it is the responsibility of the parents to apply sunscreen on your child before school. We will re-apply if needed as per authorization and instructions listed in this form.**





STEPPING STONE UNIVERSITY PRESCHOOL,

"The Stepping stone into your child's future!"

Medication: \_\_\_\_\_

Administration Route: \_\_\_\_\_

Reason for Medication: \_\_\_\_\_

Medication Storage: \_\_\_\_\_

Side Effects: \_\_\_\_\_

\_\_\_\_\_

Dosage: \_\_\_\_\_

Times of Administration: \_\_\_\_\_

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Physicians Phone Number: \_\_\_\_\_

COPY OF SIGNED PHYSICIAN ORDER MUST BE ATTACHED.

Stepping Stone University Preschool will administer the over the counter preparations listed below in accordance with the directions of use listed on the container.

Specify the brand, frequency, and duration of use for each item below.

Babywipes \_\_\_\_\_

Ointment(diaper cream, lotion etc.) \_\_\_\_\_

Baby Powder \_\_\_\_\_

Sunscreen \_\_\_\_\_

Insect Repellent \_\_\_\_\_

Other \_\_\_\_\_

I give permission to apply listed in this form and I release **STEPPING STONE UNIVERSITY PRESCHOOL (SSUP)** agents and teachers from any liability from administering any of these products listed in this form.

\_\_\_\_\_  
(Parent Sign) (Print Name) (Date)

\_\_\_\_\_  
(Parent Sign) (Print Name) (Date)





## **SIX RIGHTS OF MEDICATION**



1. **Verification that the *right* child receives**
2. **The *right* medication**
3. **In the *right* dose**
4. **At the *right* time**
5. **By the *right* method**
6. **And the *right* documentation is completed**

