Administration of Prescription RX

First & Last Name of CHILD: ____

Type/Name of Medication: ____

Start date:____

REASON:____

Prescription #: ____

Dosage:____

End Date: ____

Times & frequency:____

Route (method)*:____

I give permission for the administration of the medication, according to the instructions listed, to the child listed above.

Date of authorization:____

Signature (parent/guardian):____

POSSIBLE SIDE EFFECTS TO WATCH FOR WITH THIS MEDICATION:

* Injections: Attach health care provider's written authorization.
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FOR STAFF REVIEW PRIOR TO ADMINISTERING MEDICATION:

Is the medication consent form complete?
YES NO

Is the original prescription label on the medication container or prepackaged and labeled for use by manufacturer?
YES NO

Is the full name of the child on the container?
YES NO

Is the prescription or over-the-counter medication current?
YES NO

Is the dose, name of drug, frequency of administration given on label consistent with instructions above?
YES NO

Staff initials:__________

Medication Log

NOTES

Date_______________________________________

Time_______________________________________

Staff Name_________________________________

Staff Initials_______________________________

Date_______________________________________

Time_______________________________________

Staff Name_________________________________

Staff Initials_______________________________

Date_______________________________________

Time_______________________________________

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Staff Name_________________________________

Staff Initials_______________________________

HORIZONS
TUTORING
TO HELP YOUR KIDS SUCCEED