WEST CENTRAL MINNESOTA
Communities Action

HEAD START
West Central MN Communities Action, Inc.
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AUTHORIZATION TO ADMINISTER MEDICATION

*Medications should be given during Head Start programming **only when** failure to take medication could jeopardize the child's health. NO prescription medicine or over the counter products will be given without written permission from the parent and physician.*

Child's Name (first/mi/last): _____ ***Date of Birth:*** _____

REQUEST AND RELEASE FOR ADMINISTRATION OF MEDICATION

The following information must be provided, and the prescription or over the counter product must be sent in the original container/packaging. When possible, ask the pharmacist to divide the prescription in labeled containers, one for home and one for school/center.

Name of Medication	***Dose***	***Time to be given*** *(specify "PRN"/"as needed" conditions)*

Reason/Diagnosis: _____

Side Effects: _____

Duration of Treatment: _____ to _____

Special Instruction/Recommendations: _____

PHYSICIAN'S/HEALTH CARE PROVIDER'S SIGNATURE: **DATE:**

X_____ _____

Clinic name: _____

PARENT/LEGAL GUARDIAN ACKNOWLEDGEMENTS:

- *I understand the expiration date of this authorization is 1 (one) year from provider signature.*
- *I understand the first dose of a medication will be administered to the child at home at least 24 hours prior to observe for side effects, the exception being rescue/emergency medication.*
- *I understand Head Start staff may communicate with the provider regarding this medication information.*

PARENT/GUARDIAN SIGNATURE: **DATE:**

X_____ _____