



A CHILD'S WORLD LEARNING ACADEMY

AUTHORIZATION TO ADMINISTER MEDICATION

THIS FORM IS ACTIVE FOR 5 SCHOOL DAYS

Child's Full Name: _____

Name of Medication: _____

Amount to be given: _____

Dates to be given: _____

Times to be given: _____

Conditions being Treated: _____

Parent/ Guardian Signature: _____

Name of Medication	Times Given	Method	Amount Given	Staff Signature

ALL MEDICATIONS MUST BE IN THE ORIGINAL CONTAINER AND CHECKED INTO THE BUILDING BY A STAFF MEMBER. ONE FORM IS NEEDED FOR EACH MEDICATION TO BE GIVEN. ALL OVER THE COUNTER MEDICATIONS REQUIRE A PRESCRIPTION WITH TIME AND DOSAGE. PLEASE INFORM US IF THIS MEDICATION CAN NOT BE REFRIGERATED. ALL MEDICATION WILL BE CHECKED FOR EXPIRATION DATES. MEDS WILL NOT BE DISPENSED IF THEY ARE EXPIRED OR NOT LABELED WITH YOUR CHILDS NAME.