

**Rogers Community School Recreation Association
Rogers Activity Center**

Authorization for Medication Administration

Arkansas Minimum Licensing Standards requires all licensed child care programs to comply with regulations regarding administering of medication as well as recordkeeping. Medication shall only be given to children with signed parental permission which includes date, type, drug name, time and dosage, length of time to give medication, and what the medication is being given for. Medication shall be in the original pharmacy container with a child resistant cap, not have an expired date and be labeled with the child's name. Medication shall be returned to the parent or disposed of properly when child withdraws from the program or when the medication is out of date. Medicine shall be stored at the proper temperature, separately from food at all times.

Authorized Prescriber's Order (must be from Physician, Dentist, Physician's Assistant, or Advanced Practice Registered Nurse):

Date	Child's Name		
Medication Name			Expiration Date
What is this medication being given for?			
Dosage	Method		
Time(s) of Administration			Is this a controlled Drug? Yes No
Length of time to administer medication			
Administration Start Date	Administration Stop Date		
Relevant Side Effects	Management of side effects		
List any known allergies	List any known interactions		
Prescriber's Name	Prescriber's Phone Number		

Parent/Guardian Authorization

I request that medication be administered to my child as described above and attest that **I have administered at least one dose of the medication to my child without adverse effects.**

Child Care Program	
Child's Name	
Name of Parent Authorizing Administration of Medication	
Signature of Parent Authorizing Administration of Medication	

Name of Childcare Personnel Receiving Written Authorization of Medication _____

Title/Position _____ **Signature (in ink)** _____

Medication Administration Record

Name of Child _____ Date of Birth ____/____/____

Pharmacy Name _____ Prescription Number _____

Name of Medication _____

Dosage and how often administered _____

Date	Time	Dosage	Staff Initials	Date	Time	Dosage	Staff Initials

Attach more copies of this page if necessary

Authorization Form is complete
 Medication is appropriately labeled
 Medication is in original container
 Date on label is current

Person Accepting Medication (print name) _____
 Date ____/____/____