

## Medication Administration in School or Child Care

The parent/guardian of \_\_\_\_\_ ask that school/child care staff give the  
(Child's name)  
following medication \_\_\_\_\_ at \_\_\_\_\_  
(Name of medicine and dosage) (Time(s))

to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

The Program agrees to administer medication prescribed by a licensed health care provider.

It is the parent/guardian's responsibility to furnish the medication.

The parent agrees to pick up expired or unused medication within one week of notification by staff.

**Prescription medications** must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, and date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.

**Over the counter medication** must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the nurse or school staff delegated to administer medication.

\_\_\_\_\_  
Parent/Legal Guardian's Name

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Work Phone

\_\_\_\_\_  
Home Phone

\*\*\*\*\*

### Health Care Provider Authorization to Administer Medication in School or Child Care

Child's Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

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

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

To be given at the following time(s): \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Purpose of medication: \_\_\_\_\_

Side effects that need to be reported: \_\_\_\_\_

Starting Date: \_\_\_\_\_

Ending Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Health Care Provider with Prescriptive Authority

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Date

*Please ask the pharmacist for a separate medicine bottle to keep at school/child care.*

*Thank you!*

# GENERAL HEALTH APPRAISAL FORM

**PARENT please complete AND SIGN**

**Child's Name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_

**Allergies:**  None or Describe \_\_\_\_\_  
Type of Reaction \_\_\_\_\_

**Diet:**  Breast Fed  Formula \_\_\_\_\_  Age Appropriate  
 Special Diet \_\_\_\_\_

Sleep: Your health care provider recommends that all infants less than 1 year of age be placed on their back for sleep.

Preventive creams/ointments/sunscreen may be applied as requested in writing by parent unless skin is broken or bleeding.

I, \_\_\_\_\_ give consent for my child's care health provider, school child care or camp personnel to discuss my child's health concerns. My child's health provider may fax this form (& applicable attachments) to my child's school, child care or camp personnel. FAX #: \_\_\_\_\_ DATE: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

**HEALTH CARE PROVIDER: Please Complete After Parent Section Completed**

**Date of Last Health Appraisal:** \_\_\_\_\_ **Weight @ Exam:** \_\_\_\_\_

**Physical Exam:**  Normal  Abnormal (Specify any physical abnormalities) \_\_\_\_\_

**Allergies:**  None or Describe \_\_\_\_\_ Type of Reaction \_\_\_\_\_

**Significant Health Concerns:**  Severe Allergies  Reactive Airway Disease  Asthma  Seizures  Diabetes  Hospitalizations  
 Developmental Delays  Behavior Concerns  Vision  Hearing  Dental  Nutrition  Other \_\_\_\_\_

Explain above concern (if necessary, include instructions to care providers): \_\_\_\_\_

**Current Medications/Special Diet:**  None or Describe \_\_\_\_\_

Separate medication authorization form is required for medications given in school, child care or camp

**For Fever Reducer or Pain Reliever (for 3 consecutive days without additional medical authorization) PLEASE CHOOSE ONE PRODUCT**

Acetaminophen (Tylenol) may be given for pain or fever over 102 degrees every 4 hours as needed

Dose \_\_\_\_\_ or see the attached age-appropriate dosage schedule from our office

**OR**  Ibuprofen (Motrin, Advil) may be given for pain or for fever over 102 degrees every 6 hours as needed

Dose \_\_\_\_\_ or see the attached age-appropriate dosage schedule from our office

**Immunizations:**  Up-to-Date  See attached immunization record  Administered today: \_\_\_\_\_

**Health Care Provider: Complete if Appropriate**

**\*\*ONLY REQUIRED BY EARLY HEAD START AND HEAD START PROGRAMS PER STATE EPSDT SCHEDULE\*\***

**\*\* Height @ Exam \_\_\_\_\_ \*\* B/P \_\_\_\_\_ \*\*Head Circumference (up to 12 months) \_\_\_\_\_ \*\***

**\*\* HCT/HGB \_\_\_\_\_ \*\* Lead Level  Not at risk or Level \_\_\_\_\_**

**\*\*TB  Not at risk or Test Results  Normal  Abnormal**

**\*\*Screenings Performed:  Vision:  Normal  Abnormal  Hearing:  Normal  Abnormal  Dental:  Normal  Abnormal-**

**Recommended Follow-up \_\_\_\_\_**

**Provider Signature**

Next Well Visit:  Per AAP guidelines\* or  Age \_\_\_\_\_

This child is healthy and may participate in all routine activities in school sports, child care or camp program. Any concerns or exceptions are identified on this form.

\_\_\_\_\_

Signature of Health Care Provider (certifying form was reviewed) Date: \_\_\_\_\_

**Office Stamp**

Or write Name, Address, Phone, #

The Colorado Chapter of the American Academy of Pediatrics (AAP) and Healthy Child Care Colorado have approved this form. 04/07

\*The AAP recommends that children from 0-12 years have health appraisal visits at: 2, 4, 6, 9, 12, 15, 18 and 24 months, and age 3, 4, 5, 6, 8, 10 and 12 years.

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