ADMINSTRATION OF MEDICATION CONSENT

TO BE COMPLETED BY PHYSICIAN/PRACTITIONER:

Child's Name		Date of Birth	
Medication Name		Dosage (in mg, ml, etc.)	
Time to be Given		Route	
Duration for medication (check one)	☐ Routine Daily/As Needed	☐ Specific Dates:	to
Reason for Medication			
If "as needed," list conditions under which medication should be given.			
Possible Side Effects which may be exhibited in classroom:			

- A Prescribing Practitioner authorization is REQUIRED for all medication to be administered by staff.
- A new Administration of Medication Consent form is required for changes in medication, dosage or time.
- One form for each medication given at school is needed.
- Non FDA-approved medication cannot be administered.
- This form is valid for one year of date signed. A new form will be needed yearly for routine medications.

Physician/Practitioner's Name (print)_____ Phone_____

Physician/Practitioner's Signature_____ Date_____

☐ **Physician/Practitioner's order with signature attached**

Parental Medication Permission

I hereby give my permission to SUMMIT Early Learning, Inc. to administer this medication to my child according to the directions provided by the prescribing practitioner and to contact the child's physician if necessary. I relieve SUMMIT and its employees of liability in the administration of this medication.

Parent/Guardian Signature_____**Date**_____

SUMMIT Certification

I certify that I have reviewed and verified the above medication and paperwork is in accordance with SUMMIT policy.

SUMMIT Nurse Signature_____ Date_____