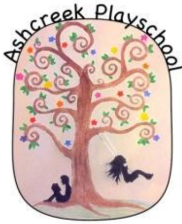

Ashcreek Playschool Permission to Dispense Medication Consent

Ashcreek Playschool will not dispense medication to a child unless directed to nt(s) and the Permission and Waiver to Dispense Medication have been fully arent/ guardian. Thank you for completing this form. If your child will be taking prescription medication during the day, we will need the medication in the original prescription bottle with specific instructions.

Child's Name: ____________________ DOB: _____________ Today's Date:_______________

Name of Medication: ____

Reason for Medication: ____

Dose: __________________________ Time/Frequency: ______________________________

Route: ▢Oral ▢Topical ▢Inhaled ▢Injection ▢Other:_________

Date to Start: ____________ Date to Stop: ____________ Expiration: _____________

Additional Instructions/Information: ____

____

Known side effects:____

For Prescription Medication:

Prescribing Provider Name & Phone Number: ______________________________________

For Controlled Substance:

Amount of Medication Received: ____

Staff Member 1 Signature and Date: ____

Staff Member 2 Signature and Date: ____

I authorize ***Ashcreek Playschool*** personnel to administer the medication named above to my child in the manner as stated. I release any liability in relation to the administration of this medication. I also acknowledge that I, the parent/guardian, have given the first dose of this medication without any allergic or unexpected reactions.

WAIVER & RELEASE OF ALL CLAIMS I recognize and acknowledge that there are certain risks of physical injury in connection with the administering of medication to my minor child. Such risks include, but are not limited to, failing to properly administer the medication, failing to observe side effects, failing to assess and/or recognize an adverse reaction, failing to assess and/or recognize a medical emergency, and failing to recognize the need to summon emergency medical services. In consideration of Ashcreek Playschool administering medication to my minor child, I do hereby fully release or discharge Ashcreek Playschool, and its Staff, from any and all claims from injuries, damages and losses I or my minor child may have (or accrue to me or my minor child), and arising out of, connected with, incidental to, or in any way associated with the administering of medication.

Parent/Guardian Signature ________________________________ Date: _________________

Printed Name ____

Return or Disposal of Medication

Return Date: ____________________ Parent Signature:_____________________________

Disposal Date:____________________ Staff Signature:______________________________

Witness to Disposal (print/sign): ____

In the event of an emergency and the parent/guardian is not available, please call:

Person to Notify__________________________________Relationship___________________

Daytime Phone____

Pertinent Medical History ____

Physician______________________________Physician's Phone _______________________

Medical Insurance Carrier______________________Policy Number:____________________

Child's Name:_________________________________ Name of Medication:_______________________________________

Child's Classroom:________________________

ALWAYS review the written Parent/Guardian medication instructions and Health Care Provider's medical order (when necessary according to regulation) prior to EVERY administration.

Instructions should be attached to this sheet. 7 Rights MUST be performed with EVERY dose!
Right **child**, Right **medication**, Right **dose**, Right **route**, Right **time**, Right **reason**, Right **documentation**

Date Given	**Time Given**	**Dose Given**	**Route Given**	**Time last dose was given by Guardian**	**Comments/ Reactions**	**Controlled Substances**			**Staff Signature**
						# on hand	**# given**	**# left**	

When medication has been discontinued, it should be returned to the parents or disposed of properly.