Medication Authorization

Child's Name: _____

Date of Birth: (mm/dd/yy)_____

Medication: _____

Centre: _____

COMPASS ELC

Centre Based Care/HCC

A SEPARATE FORM MUST BE COMPLETED FOR EACH CHILD AND/OR MEDICATION. ALL MEDICATION, PRESCRIBED OR NON-PRESCRIBED, MUST BE ACCOMPANIED BY A HEALTH PRACTITIONER'S INSTRUCTIONS.

Prescription Medication ❑ Non-Prescription Medication ❑ Health Practitioner's Instructions attached ❑

Administration Instructions:

Amount to be administered: _____ Time to be administered: _____

Storage instructions: _____ Expiry Date (mm/dd/yy):_____

Date to start Medication (mm/dd/yy): _____ Date to End Medication: (mm/dd/yy)_____

Intermittent Medication ❑ **Administer as per parent's instructions OR when the following symptoms occur:**

_____

_____

_____

STOP MEDICATION IF THE FOLLOWING REACTION(S) IS OBSERVED:

_____

_____

❑ My child is allowed to carry his/her emergency medication on his/her person and may self-administer it, only with the support of a staff member or Home Child Care Provider.

I authorize the Provider or designate to administer the above medication to my child.

_____ _____

(Parent Signature) (Date)

_____ _____

(Provider/Receiving Compass ELC Representative Signature) (Date)

STAFF: Attach the *Medication Administration & Medical Supports Record* to this *Medication Authorization*. Complete the Medication Administration Record portion each time medication is administered.