JRC EARLY CHILDHOOD CENTER
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Early Childhood Program Medication Consent Form

If it is necessary for your child to take medications at school, you must read and complete the following form. Medicine can only be given by school personnel if ordered by a physician. Medication ordered by a physician or labeled by a pharmacist needs only a parent request (part 1). Request to give over the counter medication must be accompanied by a signed request from both the physician and the parent/guardian (parts 1 and 2).

Parental Medication Request

I hereby confirm primary responsibility to administer medication to my child; however, if my child must receive medication while in school, I authorize the school director of the JRC Early Childhood Center to administer lawfully prescribed medication to my child. I acknowledge that it may be necessary that the administration of medications to my child be performed by an individual who is not a certified school nurse and specifically give my consent for such practices. I further acknowledge and agree that when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the school district and its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the school district and its employees from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication. I will notify the school of any change in medication or dosage, and will send the school a written order from the doctor when a change is necessary.

(part 1)
I give permission for school personnel to administer the following medications to _____
Name of child

1. _____ _____ _____ _____
Medication & Prescription # Dosage Time Start & Stop Dates

2. _____ _____ _____ _____
Medication & Prescription # Dosage Time Start & Stop Dates

Physician's Name _____ Pharmacy Phone _____

Parent/Guardian Signature _____ Date _____

(part 2)
Physician's signature required for over the counter medications, child to carry medications, additional clarification, etc. Requests/comments:

Physician's Signature _____ Date _____ Phone _____

I have checked the five rights of medication administration

1. Is this the right student?
2. Is this the right medication?
3. Is this the right dosage of medication for this student?
4. Is this the right time to administer the medication?
5. Is this the right route, such as a pill versus a topical ointment or shot?

Only after you have answered “yes” to all five questions should you administer the medication.

_____ Date _____

Teacher’s signature

MEDICATION ADMINISTRATION RECORD

Student Name _____ D.O.B. _____ Class _____

Date	Time	Medication	Dose	Signature/printed name of person administering