kidango
Educating Children, Inspiring Our Future

Medication Administration Form

Kidango will administer medication to children for whom a plan has been made and approved by the classroom Master Teacher or Center Director. Whenever possible, the parent/guardian should consult with his/her child's health care provider to arrange a dose schedule that does not involve the hours the child is at Kidango. Any parent/guardian may come to the classroom and administer medication to his/her own child during the day.

All Medication at Kidango:

1. Requires the parent/guardian to complete and sign this Medication Administration Form.
2. Must be in the original, child-proof container and labeled with child's name.

Prescription Medication:

1. Is administered according to the pharmacy label directions as prescribed by the child's health care provider. Container must have pharmacy label noting child's name and instructions.
2. May be authorized for one calendar month at a time. Parent/legal guardian must complete Medication Administration Form each calendar month.
3. Containers will be stored out of reach of children in a locked cabinet.
4. Unused medication will be returned to parent/legal guardian when authorized term is completed.

Non-Prescription ("Over the Counter") Medication:

1. May be used without health care provider's approval or written instructions but will be administered sparingly (for example, ointment to treat diaper rash or medication to reduce a high fever temporarily).
2. Will only be administered according to the directions on the label, unless we receive written authorization and instructions from the child's health care provider. Must be in original, labeled contatiner.

Authorization for Medication Administration

I hereby authorize designated agents of Kidango _____ Center to administer the following medication to my child, _____. I further agree to indemnify and hold harmless this center, their agents and servants against all claims as a result of any and all actions performed under this authority.

Child's Health Care Provider: _____ Telephone: _____

Parent/Legal Guardian Name: _____ Telephone: _____

Name of medication: _____

Duration of administration: _____

Method of administration: _____

Parent/Legal Guardian signature: _____ Today's Date: _____

Monthly Medication Record will be completed by person administering medication

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