

Sample

Name of Program

Medication Administration Record



(TO BE COMPLETED BY PARENT)

Picture of Child

Program Year _____

Today's Date ___/___/___

Child's Name _____

Date of Birth ___/___/___

Allergies: _____

Medication _____ Purpose _____

Dose _____ Route _____

Expected Side Effects _____

Date Received ___/___/___ Amount Received _____ Date to End ___/___/___

Medication Start Date ___/___/___ Time(s) to give _____

Additional instructions _____

(As Needed Medications Require an Individualized Care Plan)

PERMISSION TO GIVE MEDICINE

I hereby give permission for the facility/school to administer medicine as prescribed above. I also give permission for the caregiver/teacher to contact the prescribing health professional about the administration of this medicine. I have administered at least one dose of medicine to my child without adverse effects.

Parent or Guardian Name (Print)

Parent or Guardian Signature

Home Phone Number Work Phone Number Cell Phone Number

Medical Provider's Information

Name (print)

Phone Number

RECEIVING MEDICATION

To be Completed by Care Giver and Parent-Guardian

Child's Name _____

Name of medicine _____

Date medicine was received ____/____/____

Safety Check

- 1. Child-resistant container.
- 2. Original prescription or manufacturer's label with the name and strength of the medicine.
- 3. Name of child on container is correct (first and last names).
- 4. Current date on prescription/expiration label covers period when medicine is to be given.
- 5. Start and Stop date are written on the Authorization form
- 6. Name and phone number of licensed health care professional who ordered medicine is on container or on file.
- 7. Copy of Child Emergency Information is on file.
- 8. Instructions are clear for dose, route, and time to give medicine.
- 9. Instructions are clear for storage (eg, temperature) and medicine has been safely stored.
- 9. Child has had a previous trial dose. Y N
- 10. When was child's last dose given?
- 11. Parent/Guardian has given instructions on administration
- 12. Is this a controlled substance? If yes, special storage and log may be needed.
- 13. If this is an emergency medication has a 3 - Day Critical Medication Authorization Form been completed?
- 14. Expiration of medication has been checked.

Caregiver/Teacher Name (Print)

Caregiver/Teacher Signature

Sample

MEDICATION LOG Adapted from Healthy Futures Medication Administration in Early Education and Child Care Settings

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TO BE COMPLETED BY CAREGIVER/TEACHER

Name of Child _____ Weight of Child _____

	Monday	Tuesday	Wednesday	Thursday	Friday
Medication					
Date	/ /	/ /	/ /	/ /	/ /
Actual Time Given	A.M. _____ P.M. _____	A.M. _____ P.M. _____	A.M. _____ P.M. _____	A.M. _____ P.M. _____	A.M. _____ P.M. _____
Dosage/Amount					
Route					
Staff Signature					

Describe error/problem in detail in a Medical Incident Form. Observations can be noted here.

Date/time	Error/problem/reaction to medication	Action taken	Name of parent/guardian notified and time/date	Caregiver/teacher signature

Returned to Parent/Guardian	Date / /	Parent/Guardian Signature	Caregiver/Teacher Signature
Disposed Of Medicine	Date / /	Caregiver/Teacher Signature	Witness

Medication Storage Worksheet

Where do you keep / Or where would you keep:

	Medications not requiring refrigeration	Medications requiring refrigeration	Rescue Medications	Controlled substances	Other (Includes diaper cream, ora gel, sunscreen, etc.)
Locked?					
Accessible to Children?					
Exposed to moisture or heat?					
Accessible to staff? (in room, playground and on field trips)					
Change Needed					

The 5 “R”s for Safe Administration of Medication

Right Child	Right Medication	Right Dose	Right Time	Right Route
Check the name on the medication label and the child’s name	Read the label to make sure you have the correct medication	Check dose on label and Authorization form	Check the Authorization form to match the time with the label	Check the label and Authorization to Give Medicine
If any question arises, check a second identifier such as date of birth	Check to see: – Medication is in the original labeled container – Expiration date is not exceeded	Use proper measuring device	Check that medication is being given within 30 minutes before or after prescribed time	How is the medication to be given?
	Especially important for children who are taking more than 1 medication	Check measuring device carefully	Look at the clock and note the time	Drops can be used for the nose, eye or ear. Make sure you have the right one.
			The right time includes both time and date.	
			In an emergency, “now” is the right time to give medication	

Adapted from Healthy Futures Medication Administration in Early Education and Child Care Settings

Assignment
For Medication Administration Training

Instructions

1. Medication Storage Worksheet
 - a. Use the attached Medication Storage Worksheet to assess either yours or another classroom's medication storage set up.
 - b. Fill in the blanks for the medication that is currently being stored.

2. Looking at a medication that is being used in either yours or another classroom.
 - a. Fill out the Receiving Medication Form usually used when a parent checks in a medication.

You must turn in by **11/29/10**

When completed, sign below along with your STARS number and give to Angela. I will collect these, submit 2 hours of credit to STARS and send your certificate to the center. Any questions you have please write in the box below and I will answer.

Name _____ Date _____

STARS # _____

Questions: