Olympic Educational Service District 114
105 National Avenue North, Bremerton, Washington 98312
(360) 478-6887 ● 1-800-201-1300 ● FAX (360) 405-5808

Medication Authorization

Child's Name: **DOB:** **Gender: M F** **Site:**

Reason for Medication:	**If allergy, please circle the following symptoms that the child has previously experienced:** **Mouth/throat**: itching, swelling of lips tongue mouth throat **Skin**: hives swelling **Gut**: nausea cramps vomiting diarrhea **Lung:** shortness of breath coughing wheezing
Does medication need to be given at school?	Yes No
Is the medication needed during 72 hr. emergency?	Yes No

Medication	Route	Dosage Amount	Dosage Time /Frequency	Possible Side Effects

Physician Signature _____Date_____

Printed Name _____Phone_____

I authorize Head Start/ECEAP staff to give my child the above named medicine in the dosage and at the time listed.

I also give my permission for an exchange of information between Head Start/ECEAP and the licensed health care provider listed above.

Parent Signature _____Date _____

Administration/Observation Log on Back

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MEDICATION ADMINISTRATION RECORD

Child Name: **DOB:**

Complete the following when medication is **received** in the classroom/center:

Date: **Signature Parent/Guardian:** **Staff Initials:**

Complete the following when medication is **discontinued/returned** to parent/guardian:

Date: **Signature Parent/Guardian:** **Staff Initials:**

Administration/Observation Log

Medication Administered	Date/Time	Dosage	Route	Name of person administering medication	Signature of person administering medication	Comments/ Observations