

# Asthma Medication Administration Authorization

## State Prescription Medication Administration Regulations:

- **Due to State Regulations – Asthma Medication Times are only at 11:00 AM and 3:00PM.**
- **Carrington cannot administer asthma medicine at any other time of the day, per state regulations, unless an emergency situation dictates otherwise.**
- All prescription asthma medicine shall be in the original pharmacy LABELED container with complete instructions, pediatrician contact information, child’s full name, birthdate, medication name, medication description. Please place all original pharmacy labeled containers in a clear easy zip lock bag and label your child’s full name on the bag.
- Written instructions only from a parent/guardian that conforms to the prescribed medicine bottle label.
- Each FIELD of the Asthma Medication Administration Authorization must be completed.
- All medicines will be sent home on Friday each week. A new form must be completed each Monday.
- Carrington does not accept and cannot administer “As needed”, Over the Counter or Non-Prescription medicines. State requirements are very strict on this issue.

Please fill out the information below giving Carrington Academy permission to administer the prescribed medication. This is a release of the center and its employees of any adverse reactions that may occur as a result of your child taking this medication as directed. Return this form to a member of management at the front desk along with the medication. Must be completed by parent/guardian only.

Child’s Name: \_\_\_\_\_ Child’s DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Medication: \_\_\_\_\_

Prescription Number: \_\_\_\_\_ Doctor’s Name: \_\_\_\_\_

Prescribed Amount to be given: \_\_\_\_\_ Dates Meds to be given: \_\_\_\_\_

Special Instructions: \_\_\_\_\_ Reason for medication: \_\_\_\_\_

Describe steps to take if there is an adverse reaction to the medication? \_\_\_\_\_

Does your child have any medication allergies? \_\_\_\_\_ If yes, please describe: \_\_\_\_\_

Does your child have asthma or is the prescribed medicine treating an asthma related condition? \_\_\_\_\_ If yes, an asthma treatment authorization must be completed by the doctor and a release must be completed by the parent/guardian.

Parent/Guardian Name (Please Print) \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*\*\*A SEPARATE FORM IS REQUIRED FOR EACH PRESCRIPTION\*\*\***

**\*\*\*PLEASE NOTE THAT MEDICATION IS LIMITED TO ONCE A DAY AT 11:00AM\*\*\***

### For School Use Only

Day	Time <small>(Circle time medicine was given.)</small>	Amount Given	Administered By	Witnessed By	Reaction? Y or N
<b>Monday</b>	11:00 AM / 3:00 PM				
<b>Tuesday</b>	11:00 AM / 3:00 PM				
<b>Wednesday</b>	11:00 AM / 3:00 PM				
<b>Thursday</b>	11:00 AM / 3:00 PM				
<b>Friday</b>	11:00 AM / 3:00 PM				