



Medication Administration Authorization

State Prescription Medication Administration Regulations:

- **Due to State Regulations – Prescription Medication Times are only at 11:00 AM.**
- **Carrington cannot administer medicine at any other time of the day, per state regulations.**
- All prescription 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 medicines in a clear easy zip lock bag and label your child’s full name.
- Written instructions only from a parent/guardian that conforms to the prescribed medicine bottle label.
- Each FIELD of the 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	Amount Given	Administered By	Witnessed By	Reaction? Y or N
Monday	11:00 AM				
Tuesday	11:00 AM				
Wednesday	11:00 AM				
Thursday	11:00 AM				
Friday	11:00 AM				