# Medication Administration Permission Form

10A NCAC 09 .0803 (centers) and .1720 (family child care homes)

Parent/guardian completes, signs, and dates the Medication Administration Permission Form. The person accepting this form must attach the Medication Administration Record(s) to this form.

| Permission valid from date: | To date: |
|---|---|

**Only complete this box if the medication is for a child who has a chronic medical condition or an allergy**

☐ This document is written permission to administer this medication for up to 6 months.

Specific chronic medical or allergic condition: _____

Child has an: ☐ Medical Action Plan (required)

| Child's full name: | Date of birth: |
|---|---|
| Medication name: | Expiration date: |

**When to give medication (choose one):**

☐ Give medication on these specific dates and times:

☐ Give medication as needed. List the specific symptoms or circumstances needed to give the medication and how often it can be given. Ex. If Suzy has a rash and is scratching it, apply this ointment to the rash. Wait at least 6 hours before reapplying.

| Dosage (how much medication to give): |
|---|
| Route (how to give the medication): |
| Special instructions on how to give medication: |
| Possible reactions or side effects: |
| ☐ Child has received at least one dose of medication at home without reactions or side effects. |

| Prescribing health care professional name: | Phone: |
|---|---|
| Pharmacy: | Phone: |

**I give authorization to give medicine and to call the prescribing health care professional or pharmacy if needed**

| Parent/guardian name: | |
|---|---|
| Parent/guardian signature: | Date: |

**Medication received, returned, or disposed of:**

| | | | | |
|---|---|---|---|---|
| Received from parent/guardian | Date | Amount | Parent/guardian signature | Child care provider signature |
| | | | | |
| Returned to parent/guardian | Date | Amount | Child care provider signature | Witness signature |
| | | | | |
| Disposed of medicine | Date | Amount | Child care provider signature | Witness signature |
| | | | | |



NORTH CAROLINA
Child Care Health and Safety Resource Center
800-367-2229
healthychildcare.unc.edu

# Medication Administration Record

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Person who gives the child the medicine completes this Medication Administration Record. Copy this page when you need more lines to record medication administration. Attach page to the Medication Administration Permission.

**If an error occurs and the child requires medical attention, call 9-1-1 and/or Poison Control immediately.**

| Child's name: | | | | | | |
|---|---|---|---|---|---|---|
| Medication name: | | | | | | |
| Date given | Time given | Dose given | Route | Name of person giving medication | Signature of person giving medication | Reaction/side effect, if observed |
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| Date | Time | Error or mishap while giving medication | | | Parent/guardian notified? | Child care provider signature |
| | | | | | ☐ Yes ☐ No | |
| | | | | | ☐ Yes ☐ No | |
| | | | | | ☐ Yes ☐ No | |



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