Kid's Korner
EDUCARE
CENTER INC.

Medication Request and Authorization

I authorize Kid's Korner Educare to administer the following medication to:

Child's Name:		*Birth date:*	

I understand that Kid's Korner is not responsible if my child should have a reaction to the medication being administered. I understand Kid's Korner does NOT administer the initial dosage of medication, except with physician's written permission for life-threatening situations. I will provide Kid's Korner with the medication in the original prescription container and I understand that if it is not in the original container the medication cannot be administered. It is also my understanding that any over the counter medications will be dispensed only as the directions state on the bottle, with a doctor/physician signature.

Medication_____
Health Care Provider who wrote the Prescription _____
Method of Administration_____
Dosage and Time to be Given_____
Reason for Medication_____
Starting Date of Medication_____
Ending Date of Medication_____

Date	Time	Dosage	Signature of 2 (two) Staff who witness/give medication

If medication is delivered by a device, signs and symptoms from a health care provider must be attacked to this form. Staff must have be demonstrated the use do the device by the Parent, to the staff who will be delivering the medication. Staff and Parent must document training has occurred. Staff may need to be retrained if they feel it is needed, yearly, or as staff or classroom changes. By signing below, staff and parents understand training and updates must be a continuous, as needed occurrences.

By Signing Below I am stating that I have read and understand the contents of this form.

_____ _____
Parent signature **date**

_____ **Staff Names and Dates for Devices**