PARENT PERMISSION FOR MEDICATION ADMINISTRATION
PERMISO DE LOS PADRES PARA ADMINISTRAR MEDICAMENTOS

Child's Name / *Nombre del niño(a)*: ________________________ **Site** / *Salón del niño(a)*: _______________

To be completed by parent / *Para ser completada por los padres*:

I hereby authorize any person or persons designated by the Health Consultant to assist my child to take the following medications at school. / *Yo por este medio autorizo a cualquier persona o personas designadas por el Consultante de salud para que ayuden a mi niño(a) a que tome las siguientes medicinas en la escuela.*

Reason for medication /
Razón por la que toma el medicamento: ____

Name of medication /
Nombre del medicamento: ____

Possible side effects to watch for /
Posibles efectos que se deben de observar: ____

Name of prescribing physician /
Nombre del médico que prescribió el medicamento: ____

Parent/Guardian Signature /
Firma del padre/madre/tutor: ___________________________________ **Date** / *Fecha*: ____________

ALL MEDICATION MUST BE BROUGHT TO THE CLASSROOM IN THE ORIGINAL CONTAINER
TODOS LOS MEDICAMENTOS SE DEBEN DE TRAER AL SALÓN DE CLASE EN EL ENVASE ORIGINAL

MEDICATION ADMINISTRATION FLOW CHART

NAME OF MEDICATION/DOSAGE: ____

SPECIAL INSTRUCTIONS: ____

Prescription label includes: child's name, frequency and amount of dosage, name of the drug, duration of administration, method of administration, expiration date, storage instructions, date filled, and name of the prescribing physician.

Staff Signature: ____

Date	Time	Name of Medication and Dosage	Note any side effects observed	Signature of person administering medication
1				
2				
3				
4				
5				

A separate flow sheet must be completed for every medication a child is taking during Head Start classroom hours, and the medication must be documented every time it is given.

ORIGINAL: Site File, Section 2 COPY 1: to Parent COPY 2: to Health Consultant COPY 3: to be kept with medication