



**COMMUNITY BEFORE & AFTER SCHOOL
CHILD CARE PROGRAM (CAP)**



MEDICATION AUTHORIZATION FORM

Child Information

Child's Full Legal Name		Nickname	
Date of Birth	Age	<input type="checkbox"/> Male	<input type="checkbox"/> Female
School Attending in Fall	CAP Site		
Home Address	City	Zip	
Home Phone	Cell Phone	Work Phone	

Medication Information

Medication	Dosage		
Purpose			
Times to Dispense			
Date to Begin Dispensing	Date to End Dispensing		
Possible Side Effects/Special Instructions/Precautions			
Prescribing Physician Name	Physician Phone		

Instructions

Medication shall be available with the child's name, the name of the medication, the dosage amount and the time or times to be given (listed on page 2). Prescription medication shall be in the original prescription container labeled with the child's name, drug name, dosage, directions for administering, physician's name, and pharmacy name and address. The label qualifies as authorization to give the medication. Staff members will keep all medication in a specified locked container. Medications will not be administered if the expiration date has passed. Medication shall be returned to the parent as soon as the medication is no longer being administered. If medication is not picked up it will be discarded. Long-term prescription drug use may be allowed with written authorization from the child's physician and parent/guardian. Verification chart of medication administration is on the reverse of this sheet.

In-Service and Vacation Days

IMPORTANT: During In-Service and/or Vacation days parents/guardians are responsible for the transfer of prescription or non-prescription medications to the appropriate CAP site. CAP will not be held liable for any missed doses/medication.

Agreement

I hereby give my permission for my child to take the above medication at school as ordered. I understand that it is my responsibility to furnish this medication and bring it to school. I hereby request that my child be given the above medication while at CAP. I understand that non-medical personnel may give the medication. I understand that medication administration will not begin until this form is on file and personnel have received instruction concerning administration of medication. I further understand and agree that the Community Before & After School Child Care Program, its officers, agents, and employees are not responsible for any effects of the medication administered. I understand that I must notify the school in writing of any changes in my child's condition, medication, or dosage. I further understand that I am responsible for ensuring that medication safely arrives at school and for providing refills of the medication as indicated.

Parent/Guardian Signature	Date
Parent/Guardian Signature	Date

"The USDA and the State of Oregon are equal opportunity providers and employers."

