CCL.026
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Kansas Department of Health and Environment
Bureau of Family Health
Child Care Licensing Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
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Website: www.kdheks.gov/kidsnet

Authorization for Dispensing Medications to Children or Youth
Short-Term Medications (Prescription and Non-Prescription)

Prescription medications must be in their original containers labeled with the child's or youth's first and last name, the date the prescription was filled, the name of the licensed physician or licensed nurse practitioner who wrote the prescription, the expiration date of the medication, and specific and legible instructions for administration and storage of the medication. Administer the medication according to the instructions. **Non-prescription medications** can be given by permission and direction from the parent, guardian or legal custodian based on general advice received from the child's or youth's physician. Administer nonprescription medication from the original container labeled with the first and last name of the child or youth and according to the instructions on the label.

Medication #1

____
First and Last Name of Child or Youth

____
Name of Medication

____
Reason for Medication

____
Dose Time to be Given Stop Date

____
Name of Licensed Physician/Nurse Practitioner prescribing the medication

(_________)_____________________________
Phone number of Health Care Provider

I allow the above medication to be given to my child or youth by the child care provider/staff member or school age program staff member.

____
Parent's Signature Date

Medication #2

____
First and Last Name of Child or Youth

____
Name of Medication

____
Reason for Medication

____
Dose Time to be Given Stop Date

____
Name of Licensed Physician/Nurse Practitioner prescribing the medication

(_________)_____________________________
Phone number of Health Care Provider

I allow the above medication to be given to my child or youth by the child care provider/staff member or school age program staff member.

____
Parent's Signature Date

THIS FORM IS TO BE USED TO DOCUMENT ADMINISTRATION OF ONLY THE MEDICATION(S) IDENTIFIED ABOVE. Provider or staff member to note any comments or remarks about the child's or youth's appearance on the back of this form.

Date mm/dd/yy	Time	Name of Medication	*Initials	Date mm/dd/yy	Time	Name of Medication	*Initials

Each person administering medication is to sign on the back side of this form and identify initials used above.

*Signature of Person Administering Medication ____ Initialing as___________

*Signature of Person Administering Medication ____ Initialing as __________

*Signature of Person Administering Medication ____ Initialing as __________

*Signature of Person Administering Medication ____ Initialing as __________

Note Form

Date	Comments about the incident or other related incidents, including remarks about the child’s or youth’s appearance.