Coastal Community Action Inc.

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Edith J. Travers
Executive Director

Medication Form

TO BE COMPLETED BY PHYSICIAN

CHILD'S NAME:___________________________________ **Date of Birth**:______________________

Name of Medication:____

Dosage:____

When to give:____

To be given FROM (Dates):____________________________ **TO**:___________________________________

Diagnosis for which medication was prescribed:____

Possible side effects to be noted: ____

____

Emergency Instructions: ____

____

Physician's Signature:____________________________________ **Date**:__________________________

DEA #:________________________ **Physician's Phone Number**:__________________________________

TO BE COMPLETED BY PARENT/GUARDIAN

I HEARBY GIVE MY PERMISSION FOR MY CHILD______________________________________ TO RECEIVE MEDICATION DURING SCHOOL HOURS. A LICENCED PHYSICIAN HAS PRESCRIBED THIS MEDICATION. I HEARBY REALEASE ALL HEAD START/EARLY HEAD START EMPLOYEES FROM ANY AND ALL LIABILITY THAT MAY RESULT FROM MY CHILD TAKING HIS/HER PRESCRIBED MEDICATION.

PARENT/GUARDIAN SIGNATURE:____

DATE:__________________________ PARENT'S HOME PHONE NUMBER:______________________

EMERGENCY CONTACT PERSON:_________________________ PHONE NUMER:___________________

CENTER USE ONLY

NAME AND TITLE OF PERSONS TO ADMINISTER MEDICATION:

1. _____________________________ 4. ___________________________

2. _____________________________ 5. ___________________________

3. _____________________________ 6. ___________________________

CENTER MANAGER SIGNATURE:_____________________________ DATE:_________________________