

Administration of Medicine

NAME OF CHILD: _____ AGE: _____

MEDICATION TYPE:

- Prescription
- Non-Prescription

ROUTE OF MEDICATION:

- Topical
- Oral
- Other

Prescription Medications: must have a current pharmacist's label that includes the child's full name, dosage, current date, times and number of days to be administered, and the name and telephone number of the physician.

Non-prescription Children's Medication: can be administered for up to *three consecutive days* with a written order from the parent/guardian according to manufacturer's instructions. Medication instructions must note how much medication to give based on the child's age and weight. Written authorization from the child's medical provider is required to continue use beyond the three consecutive days.

Non-prescription Topical Children's Ointments: can be applied according to the manufacturer's instructions with authorization from the parent/guardian for a period not to exceed *six months*. Medication instructions must note how much medication to apply based on the child's age and weight. This includes sunscreen, insect repellent, and other non-medicated (free from antibiotic, antifungal or steroidal components) topical ointments designated for use for children.

As Needed Children's Medications: requires a written order from the child's medical provider for a period not to exceed *six months*. Authorization must list the reason, dosage, start date and end date. Dosage cannot state "as needed"; rather must list specific dosage times or symptoms for which medication should be given.

Medications for Chronic Illnesses: requires a written order from the child's medical provider for a period not to exceed *one year*. (See Prescription and Non-prescription medication above for details)

Note: All medications must be provided in the original container, labeled with the child's full name and any medication spoon/device to administer the medication must be provided. Non-prescription medications must be designated for use for children.

PARENT AUTHORIZATION AND ACKNOWLEDGEMENT:

I have read the policy of Administering Medications and Ointments in the Parent Handbook and I hereby authorize Chestnut Hill Academy to administer the following medications to my child. I further agree to indemnify and hold harmless Chestnut Hill Academy and their agents and servants, against all claims as a result of any and all acts performed under this authority.

MEDICATION: _____

REASON FOR MEDICATION: _____

DOSAGE: _____ TIMES TO BE GIVEN: _____

START DATE: _____ END DATE: _____

SIDE EFFECTS: _____

STORAGE: _____

DOCTOR'S NAME: _____

DOCTOR'S PHONE NUMBER: _____

DOCTORS SIGNATURE: _____

PARENT'S SIGNATURE: _____ DATE: _____