

## AUTHORIZATION TO ADMINISTER MEDICATION – CHILD CARE CENTERS

**Use of form:** This form is mandatory for family child care centers to comply with DCF 250.07(6)(f)1.a. Failure to comply may result in issuance of a noncompliance statement. This form is voluntary for group child care centers, day camps and certified providers; however, completion of this form meets the requirements of DCF 251.07(6)(f)1.a., DCF 252.44(6)(e)1.a. and DCF 202.08(4)(f) and 202.09(5)(c)., Wis. Admin. Codes. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

**Instructions:** When a parent is requesting prescription or non-prescription medication be administered to a child in care, this form shall be completed and signed by the parent or guardian before any medication is administered. A separate form shall be used for each medication. Place form in child's file when medication is no longer required / authorized.

**Licensed Child Care Centers:** Log the dates and times medication was administered in the center medical log. Blanket authorizations that exceed the length of time specified on the label are prohibited; no medication intended for use by a child in the care of the center may be kept at the center without a current medication administration authorization from the parent.

### A. FACILITY AND CHILD INFORMATION

Name – Child Care Center

Name – Child

Birthdate (mm/dd/yyyy)

**B. MEDICATION INFORMATION:** Medication shall be in the original container and labeled with the child's name. The label shall include dosage and directions for administration.

Name – Medication	Dosage	Time(s) of Day to be Administered	How to be Administered	Dates – Medication Time Period	
				From	To
		<input type="checkbox"/> AM <input type="checkbox"/> PM ----- <input type="checkbox"/> AM <input type="checkbox"/> PM ----- <input type="checkbox"/> AM <input type="checkbox"/> PM ----- <input type="checkbox"/> AM <input type="checkbox"/> PM			

Yes  No **Does the over-the-counter (OTC) medication label indicate the child's physician should be consulted?** If "Yes" I have consulted with my child's physician, and I am authorizing a dosage consistent with the physician's recommendation.

\_\_\_\_\_

Name – OTC Medication

\_\_\_\_\_

Parent Initials

Additional information / special instructions / contraindications – Specify.

### C. AUTHORIZATION

I hereby authorize administration of the above medication to my child by staff of the child care center listed above.

**SIGNATURE** – Parent or Guardian

Date Signed