Rogers Community School Recreation Association
Rogers Activity Center

Authorization for Medication Administration

Arkansas Minimum Licensing Standards requires all licensed child care programs to comply with regulations regarding administering of medication as well as recordkeeping. Medication shall only be given to children with signed parental permission which includes date, type, drug name, time and dosage, length of time to give medication, and what the medication is being given for. Medication shall be in the original pharmacy container with a child resistant cap, not have an expired date and be labeled with the child's name. Medication shall be returned to the parent or disposed of properly when child withdraws from the program or when the medication is out of date. Medicine shall be stored at the proper temperature, separately from food at all times.

Authorized Prescriber's Order (must be from Physician, Dentist, Physician's Assistant, or Advanced Practice Registered Nurse):

Date		Child's Name	
Medication Name		Expiration Date	
What is this medication being given for?			
Dosage		Method	
Time(s) of Administration		Is this a controlled Drug?	Yes No
Length of time to administer medication			
Administration Start Date		Administration Stop Date	
Relevant Side Effects		Management of side effects	
List any known allergies		List any known interactions	
Prescriber's Name		Prescriber's Phone Number	

Parent/Guardian Authorization

I request that medication be administered to my child as described above and attest that **I have administered at least one dose of the medication to my child without adverse effects.**

Child Care Program	
Child's Name	
Name of Parent Authorizing Administration of Medication	
Signature of Parent Authorizing Administration of Medication	

Name of Childcare Personnel Receiving Written Authorization of Medication _____

Title/Position _____ Signature (in ink) _____

Medication Administration Record

Name of Child ____ Date of Birth _____/_____/_____

Pharmacy Name ____ Prescription Number _________________

Name of Medication ____

Dosage and how often administered ____

Date	Time	Dosage	Staff Initials	Date	Time	Dosage	Staff Initials

Attach more copies of this page if necessary

___ Authorization Form is complete

___ Medication is in original container

___ Medication is appropriately labeled

___ Date on label is current

Person Accepting Medication (print name) ____

Date _____/_____/_____