Mountainland Head Start, Inc.

AUTHORIZATION TO ADMINISTER MEDICATION

Child _____ Date of Birth _____

Parent / Guardian _____ Phone # _____

Health Care Provider _____ Phone # _____

For their own safety, any child who needs medication administered while at school will not be allowed to attend class until this form has been signed by a physician and returned to our Administrative Office.

Parent / Guardian Agreement and Approval

- I hereby authorize any person or persons designated by the Mountainland Head Start Health Services Coordinator to administer the following medication(s) to the above-named child.
- I give my permission for exchange of information between Mountainland Head Start and the prescribing health care provider.
- I understand that the medication is to be furnished by me, in the original container, labeled by the pharmacy, with the name of the prescribing health care provider, name of the medication, the amount to be taken, and frequency of administration.
- I understand that in case of serious side effects, Mountainland Head Start staff will follow agency procedures necessary for the well-being of my child.
- I understand that this form must be completed with signatures before any medication will be administered to my child while at Head Start and I accept full liability for not providing medication and instructions.

Parent / Guardian Signature _____ **Date** _____

PRESCRIPTION DOSING INSTRUCTIONS

Must be completed by Health Care Professional

Diagnosis / Medical Condition Requiring Medication(s) _____

	Regularly Scheduled Medication	**Emergency Medication**
Medication Name		
Route		
Dosage		
Schedule		
Storage		
Possible Side Effects		
Treatment Period		
Special Instructions		

_____

Name of Health Care Provider

_____ _____

Health Care Provider Signature Date

FOR OFFICE USE ONLY : HSC/NSC REVIEW & ENTRY _____ → HS review & file _____ Teacher Initials _____

Initial & Date Cook Initials if due to SMP _____

Mountainland Head Start, Inc.

AUTORIZACION PARA LA ADMINISTRACION DE MEDICAMENTOS

Nombre del Niño(a) _____ Fecha de Nacimiento _____
Padre/Tutor _____ # de Teléfono _____
Proveedor de Servicios de Salud _____ # de Teléfono _____

Por su propia seguridad, cualquier niño que necesite tomar algún medicamento en la escuela no se le permitirá asistir a clases hasta que este formulario haya sido firmado por un doctor y entregado a la Oficina Administrativa.

Acuerdo y Aprobación del Padre o Tutor

- Por la presente autorizo a cualquier persona o personas designadas por el coordinador de servicios de salud de Mountainland Head Start para administrar los siguientes medicamentos al niño(a) mencionado en la parte superior de este formulario.
- Doy autorización para el intercambio de información entre Mountainland Head Start y el doctor que receto el medicamento.
- Entiendo que yo debo de proveer el medicamento en su envase original, etiquetado por la farmacia, con el nombre del doctor que lo receto, nombre del medicamento, cantidad que se debe administrar y cada cuando debe ser administrado.
- Yo entiendo que en caso de algún efecto secundario grave, el personal de Mountainland Head Start seguirá los procedimientos de la agencia necesarios para el bienestar de mi hijo(a).
- Yo entiendo que este formulario debe estar firmado antes de que cualquier medicamento sea administrado a mi hijo(a) cuando este en Head Start y acepto toda la responsabilidad si no proveo el medicamento e instrucciones.

Firma del Padre o Tutor _____ **Fecha** _____

PRESCRIPTION DOSING INSTRUCTIONS

Must be completed by Health Care Professional

Diagnosis / Medical Condition Requiring Medication(s) _____

	Regularly Scheduled Medication	**Emergency Medication**
Medication Name		
Route		
Dosage		
Schedule		
Storage		
Possible Side Effects		
Treatment Period		
Special Instructions		

_____
Name of Health Care Provider

_____ _____
Health Care Provider Signature Date

FOR OFFICE USE ONLY ☐ HSC/NSC REVIEW & ENTRY _____ → _____HS review & file _____Teacher Initials
Initial & Date
_____ Cook Initials if due to SMP