

N.W.C.A. Head Start/Early Head Start
312 North Main Street - P.O. Box 67
Badger, MN 56714
1-800-568-5319 or 528-3227

ADMINISTRATION OF MEDICATION POLICY

1. The primary responsibility for medication administration is that of the parent under the direction of a physician.
2. For the child who requires medication to be administered during normal Head Start Center hours, the following guidelines will be followed:
 - a. **All prescription medications** will be administered by trained Head Start staff as noted in parent permission form.
 1. Prior to the administration of any medication, written authorization of a parent/guardian shall be obtained. A pharmacy label is not an order.
 2. All prescription medications must be in an original container with doctor's orders on the label.
 - b. **All non-prescription medications** must have written orders by a doctor and Permission for Administration Form completed by parent.
3. All Medications should be stored in a locked cabinet.
4. All Head Start staff will be made aware of children with life threatening emergency conditions.
5. Classroom teachers and other appropriate school personnel shall be notified of side effects and/or toxic reactions or special precautions while they are responsible for the particular child.

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PARENT PERMISSION TO ADMINISTER MEDICATION & LOG FORM

Name of medication: _____ Date prescribed: _____
For (problem or illness): _____

Date last dose due: _____

For Parent to complete:

I _____ (parent or guardian) give permission to
_____ (name of authorized child care staff)
to administer _____
(amount) of _____ (name of medication) to my child,
_____ (name of child)
at approximately _____ (time[s]) on _____ (date[s])
by _____ (body location and method of use).

Possible side effects to watch for with this medication

The name and phone number of the physician who prescribed the medicine

Parent signature: _____ Date: _____

For Staff to complete:

Give medicine **only** if you can answer **yes** to all questions below.

Is the permission form above completed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the medication in a child-proof container?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the original prescription label on the medication container?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the name of this child on the container?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the date of the prescription current?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

(Within the month for antibiotics and within the expiration date for medications which are so labeled; within the year otherwise?)

Caregiver signature: _____

