AUTHORIZATION TO ADMINISTER PRESCRIPTION AND NON PRESCRIPTION MEDICATION

IN ACCORDANCE WITH HE C 4002.20, THIS FORM MUST BE COMPLETED PRIOR TO THE ADMINISTRATION OF ANY PRESCRIPTION OR NON PRESCRIPTION MEDICATION

PRESCRIPTION MEDICATION WILL BE ADMINISTERED IN ACCORDANCE WITH THE PRINTED PRESCRIPTION LABEL, WHICH MUST BE ATTACHED TO THE ORIGINAL PRESCRIPTION CONTAINER.

NON PRESCRIPTION MEDICATION MUST BE IN ORIGINAL CONTAINER, AND WILL BE ADMINISTERED IN ACCORDANCE WITH THE MANUFACTURER'S PRINTED INSTRUCTIONS. IF THERE ARE NO MANUFACTURER'S PRINTED INSTRUCTIONS FOR THE AGE OF THE CHILD, THE PROGRAM MAY ADMINISTER THE NON-PRESCRIPTION MEDICATION IN ACCORDANCE WITH THE WRITTEN, DATED AND SIGNED INSTRUCTIONS FROM THE CHILD'S PARENT, INCLUDING A STATEMENT THAT THE INSTRUCTIONS HAVE BEEN REVIEWED/APPROVED BY THE CHILD'S LICENSED HEALTH PRACTITIONER, OR WITH SIGNED, DATED WRITTEN INSTRUCTIONS FROM CHILD'S LICENSED HEALTH PRACTITIONER.

PARENT'S AUTHORIZATION

I AUTHORIZE CHILD CARE PERSONNEL AT ______________________________ TO ADMINISTER THE
NAME OF CHILD CARE PROGRAM

FOLLOWING MEDICATION TO MY CHILD: ______________________________ ____________
CHILD'S NAME DATE OF BIRTH

NAME OF MEDICATION	DOSAGE	TIMES TO ADMINISTER	BEGINNING DATE	ENDING DATE

____
PRINTED NAME AND PHONE NUMBER OF CHILD'S LICENSED HEALTH PRACTITIONER

______________________________ ____________
PARENT/GUARDIAN'S SIGNATURE **DATE SIGNED**

SPECIAL INSTRUCTIONS FOR ADMINISTRATION OF NON-PRESCRIPTION MEDICATION:

THE ABOVE SPECIAL INSTRUCTIONS WERE:
- ☐ **REVIEWED AND APPROVED BY THE ABOVE NAMED LICENSED HEALTH PRACTITIONER**
- ☐ **COMPLETED BY THE LICENSED HEALTH PRACTITIONER WHO'S SIGNATURE IS BELOW**

______________________________ ____________
LICENSED HEALTH PRACTITIONER'S SIGNATURE **DATE SIGNED**

CHILD CARE PROGRAM RECORD OF MEDICATION ADMINISTRATION

(TO BE COMPLETED BY CHILD CARE PERSONNEL FOR ALL MEDICATION ADMINISTERED)

NAME OF MEDICATION	AMOUNT	TIME	DATE	INITIALS

NAME OF MEDICATION	AMOUNT	TIME	DATE	INITIALS

NAME OF MEDICATION	AMOUNT	TIME	DATE	INITIALS

NAME OF MEDICATION	AMOUNT	TIME	DATE	INITIALS

______________________________ ____________
SIGNATURE AND POSITION TITLE OF PERSON SUPERVISING ADMINISTRATION/CONTROL OF MEDICATION DATE SIGNED

Sunrise
Children's Center
An RSEC Program

I _____, parent or guardian of _____ give my permission for Sunrise Children's Center staff to apply the following topical lotions/sprays to my child as needed.

_____ sunscreen

_____ insect repellent

_____ diaper cream (non-prescription)

_____ powder

Parent/Guardian Signature: _____

Teacher or Director Signature: _____

Date: _____

- Any special directions:

PERMISSION TO ADMINISTER NON-PRESCRIPTION TOPICAL SUBSTANCES

I ____, parent or guardian of _______________________ give permission for staff at Sunrise Children's Center to apply the following :

____
NAME OF NON-PRESCRIPTION TOPICAL SUBSTANCE

____
WHEN TO APPLY AND HOW TO APPLY

____
ANY OTHER INFORMATION

____
PARENT/GUARDIAN SIGNATURE DATE

____
TEACHER OR DIRECTOR SIGNATURE DATE

DATE	PERSON ADMINISTERING		DATE	PERSON ADMINISTERING

ALLERGY ACTION PLAN

Allergy to: _____

Student's Name: _____

DOB: _____ Center/Classroom: _____

Asthmatic Yes* ☐ No ☐ (*High risk for severe reaction)

Place Child's Picture Here

SIGNS OF AN ALLERGIC REACTION

Systems	Symptoms
Mouth	Itching & swelling of the lips, tongue, or mouth
Throat**	Itching &/or a sense of tightness in the throat, hoarseness, & hacking cough.
Skin	Hives, itchy rash, &/or swelling about the face or extremities.
Gut	Nausea, abdominal cramps, vomiting, &/or diarrhea
Lung**	Shortness of breath, repetitive coughing, &/or wheezing.
Heart**	"Thready" pulse, "passing out"

The severity of symptoms can quickly change. ***All of the above symptoms can potentially progress to a life-threatening situation.*

♦ACTION FOR MINOR REACTION♦

1. If **only symptom(s)** are: _____, then give _____.
   Medication/dose/route
2. Then call:
   Parent/Guardian (1):_____, Parent/Guardian (2)_____, or emergency contacts.
2. Then call:
   Dr. _____ at _____

If condition does not improve within 10 minutes, follow steps for major reaction below.

♦ACTION FOR MAJOR REACTION♦

1. If ingestion is suspected &/or symptoms are:_____, give_____**IMMEDIATELY!**
   Medication/dose/route
2. **Then Call:**
   Rescue Squad (ask for advanced life support) - **911**
3. Parent/Guardian (1):_____, Parent/Guardian (2)_____, or emergency contacts.
4. Dr. _____ at _____

DO NOT HESITATE TO CALL 911!

Parent/Guardian Signature:_____ Date:_____

Revised June 2007