

## Medication Authorization

### MEDICATION *(To be completed by parent)*

CHILD'S NAME	AGE	CLASSROOM
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I authorize Bayview Christian School & Child Development Center staff to dispense the following prescription medication, over the counter medication or supplement to the above named child as directly by the physician. In addition, I will provide a list of potential side effects, obtained at the pharmacy, for prescription medication.

MEDICATION/SUPPLEMENT	DOSAGE (must match label's dosage)	SCHEDULED TIME*	ROUTE OF ADMINISTRATION	AUTHORIZED DATES		PARENT INITIALS
				START	STOP	

Physician Ordered                       Parent/Legal Guardian Ordered

### Medication Policy Statement:

- All prescription medications, dietary supplements and over-the-counter medication that requires dosing different than what is listed on the packing for the child's age, must have physician and parental approval before they can be dispensed by Bayview Christian School.
- Physician authorization is designated by the prescription. In the case of an over-the-counter medication written instructions are required from the treating physician if dosing is different from labeled directions.
- Parents must provide the measuring and dispensing devices.
- All medications must be taken home on Friday or the child's last day of attendance for the week. The three exceptions are:
  - Emergency medication
  - Medication needed at the center by School age children who do not arrive with their parents on the first day of the week (i.e., parents drop off at school, Bayview Christian School transports from school to the center).
  - Topical ointments can remain at the center until they are no longer needed or until the authorization form has expired.

This Medication Authorization form must be completed on or before the first day the child is to receive the medication, and the form must be updated based on the type of medication or as required by State Law.

### Authorization Guidelines:

- **Temporary Medication:** Valid until all medication is administered.  
Both prescription and non-prescription medication that will be administered due to a temporary health condition. This includes but is not limited to antihistamines/decongestants, acetaminophen (aspirin substitutes), cough suppressants and antibiotics.
- **Continuous Medication:** Updated as medication dose is changed or every 90 days.
- **Intermittent Emergency Medication:** Updated as medication dose is changed or every 90 days.

*Medication for emergency use will also require a Medical Emergency Response Plan to be completed and on file.*

ANY KNOWN ADVERSE REACTIONS:	PARENT INITIALS	DATE

### **SIGNATURE**

***(Required)***

\_\_\_\_\_

*PARENT SIGNATURE*

\_\_\_\_\_

*DATE*

\_\_\_\_\_

*CHILD'S NAME*

Side 1



## Topical Ointment Authorization

Authorize form for the application of non-prescription topical ointments and/or creams, including but not limited to sunscreen, bug repellent, diaper ointment, or teething gel. *All containers are to be marked with the child's name in permanent marker. Authorization Form must be completed for each non-prescription topical ointment and/or cream.*

CHILD'S NAME	AGE	CLASSROOM
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I authorize Bayview Christian School & Child Development Center staff to apply the following non-prescription topical ointments and/or creams to the above-mentioned child, as needed for the following reasons only. I understand that these products will only be applied according to labeled directions. Any deviations from labeled directions will require a treating physician's written authorization. For children under two (2) years, please insure their age is represented on the label or a treating physician's written authorization will be required.

TOPICAL OINTMENT/CREAM	WHERE ON THE BODY TO BE APPLIED	WHEN TO BE APPLIED	START DATE	EXPIRATION DATE	PARENT INITIALS

This authorization is valid for 90 days. Upon expiration, place in child's file.

ANY KNOWN ADVERSE REACTIONS:	PARENT INITIALS	DATE

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*PARENT SIGNATURE*

\_\_\_\_\_  
*DATE*

