**AUTHORIZATION TO DISPENSE MEDICATION**

I hereby authorize (*Name of Child Care Program)* to administer the following prescription and/or over-the-counter medication(s) to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, .

*Name of Child Date of Birth*

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Medication: | Dosage: | Time(s) of Administration: | Prescribing physician (When applicable): |
|  |  |  |  |
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**MEDICATION MUST BE IN ITS ORGINAL CONTAINER WITH THE CHILD’S NAME ON IT.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Parent or Guardian (Please print) Signature of Parent or Guardian Date

**Updates and Changes: Medications added, discontinued, or dosages/times changed:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication/Dosage: | Change: | If an addition, time(s) of administration: | Signature of Parent or Guardian | Date |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Instructions for completing Medication Administration Form:

* Anyone who is responsible for administering medication to this child must sign and initial the MAR.
* “Route” refers to how the medication in administered: orally, by injection, or topically.
* Any omissions from administering medications as prescribed should be noted by a circle instead of initials, and a corresponding note should be entered.
* Program closure days, such as weekends and holidays, should be indicated with an “X”.