GERRARD EARLY LEARNING CENTRE

163 GERRARD ST. EAST, TORONTO ONTARIO, M5A 2E4 Tel: 416 926-2208 Fax: 416-926-9086

AUTHORIZATION FOR DRUG/MEDICATION ADMINISTRATION

This form must be completed by the parent of a child who is requesting that a drug or medication be administered during hours that the child receives child care, in accordance with the child care centre's medication administration policy and procedures.

Child's Full Name:

Child's Date of Birth (dd/mm/yyyy)**:** _____

Date Authorization Form Completed (dd/mm/yyyy)**:**_____

Date Authorization Form Updated (dd/mm/yyyy)**:**_____

Parent/Guardian Authorization Statement:

I hereby authorize the person in charge of drugs or medications at Gerrard Early Learning Centre to administer the above-named drug or medication to my child and handle the drug or medication in accordance with the procedures I have provided on this form.

I understand that expired drugs or medications will not be administered to my child at any time in accordance with the child care centre's medication administration policy.

I understand that staff at Gerrard Early Learning Centre are not medically trained to administer drugs and medications.

Print name:	**Relationship to Child:**
Signature:	**Date Signed:** (dd/mm/yyyy)

Received By:

Print name:	**Role at Child Care Centre:**
Signature:	**Date Signed:** (dd/mm/yyyy)

Name of Drug or Medication (as per the original container label):	
Date of Purchase or Date Dispensed: (dd/mm/yyyy)	
Expiry Date: (dd/mm/yyyy)	
Authorization Start Date: (dd/mm/yyyy)	
Authorization End Date: (dd/mm/yyyy or ongoing)	

Method of Medication Administration (initial below)

☐ Child care centre staff are to administer the drug or medication to my child. _____

Medication Administration Schedule

☐ The drug or medication needs to be administered according to the following schedule:

Day(s) of the Week	Time(s) of the Day / Intervals	Amount/Dosage	Additional Information (where applicable)

AND/OR, where drugs are to be administered on an 'as needed' basis:

☐ The drug or medication needs to be administered when the following physical symptoms are observed:

Symptoms: Amount/Dosage:

RECORD OF DRUG/MEDICATION ADMINISTRATION

*This form must be completed by the person who is in charge of drugs and medications for the administration of **prescription or over-the-counter medications,** in accordance with the child care centre's medication administration policy and procedures.*

Date (dd/mm/yyyy)	**Time** (hh:mm am/pm)	**Dosage Administered**	**Administered by Full Name of Staff**	**Signature(s)**	**Comments/Observations (including symptoms of illness)**

For Child Care Centre Use Only

Location medication will be stored: _____

Date Drugs/Medication Returned to Parent / Pharmacy (dd/mm/yyyy)**:**_____