Reach-Up
Head Start
Early Head Start

Head Start
Early Head Start

United Way

Permission to Administer Medication

Reach-Up Early Head Start/ Head Start Medication Policy require written instructions by a physician/dentist if a child is to be given oral or external medication during program hours. **This permission to administer medication form must be signed by the parent and the physician/dentist**. Medication must be labeled with the name of drug, directions of use, expiration date and in the original container.

Child's Name: _____ DOB: _____

Medication: _____

Condition for which prescribed: _____

Instructions for use: _____

Dosage: _____

Frequency: _____ Time: _____# of Days: _____

Possible side effects: _____

I have prescribed the above medication for this child and request that the dosage falling during program hours be administered by Reach-Up staff.

Health Care Provider (please print name): _____

Clinic: _____ **Phone:** _____

Signature of physician/dentist: _____ **Date:** _____

I request the above medication to be given by Reach-Up staff to my child as prescribed by the physician/ dentist identified above.

Signature of Parent: _____ **Date**: _____

I have obtained the above medication from the child's parent and have verified the 6 rights (child, medication, time, dose, route, medication record) as identified above:

Signature of Reach-Up Staff: _____ **Date:** _____

Medication Expiration Date: _____

A COPY OF THIS FORM MUST BE SUBMITTED TO THE NURSE AS SOON AS ALL SIGNATURES HAVE BEEN OBTAINED.

350 Highway 10 South Suite 100 | St. Cloud MN, 56304
Voice: 320.253.8110 | Fax: 320.253.1107 | www.reachupinc.org

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Disposition of Medicine

Child's Name: _____ DOB: _____

Medication: _____

Condition for which prescribed: _____

Medication Expiration Date: _____

I have returned the above medication to child's parent in the original container that it was received in.

Signature of Reach-Up Staff: _____ Date: _____

Reach-Up staff has returned the above medication to me in the original container that it was received in.

Signature of Parent: _____ **Date: _____**

A COPY OF THIS FORM MUST BE SUBMITTED TO THE NURSE AS SOON AS ALL SIGNATURES HAVE BEEN OBTAINED.

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