Head Start
Early Head Start

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: _______________________________ Needed with transportation? ____________

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 | 1.877.848.4912 | Fax: 320.253.1107 | www.reachupinc.org

Reach-Up Head Start and Early Head Start provides comprehensive education and support services that strengthen young children and their families who are experiencing low-income.

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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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