Trumbull Loves Children, Inc. Authorization for Prescription Medications

Order of an authorized Prescriber

Name of Child: ______________________________ Date: ________________________

Address: ____ Date of Birth: _________________

Drug Name: ____ Dosage: ______________________

Method of Administration: ____

Time to be Administered: ____

Dates to be Administered: From: ________________________ To: _________________________

Relevent side effects to be observed if any: ____

____

Medication has been administered previously without complications: ______________________________

If there are any side-effects, plan for management: ____

____

Is this a controlled drug? ____

Allergies to food or drugs? If Yes, list: ____

Authorized Prescriber's Name: _____________________________ Phone: ____________________

Authorized Prescriber's Signature: ____

Authorization by Parent/Guardian for the Administration of the above medication

To authorized Provider:

I hereby request that the above medication, ordered by the authorized PRESCRIBER for my child, ____, be administered by the authorized provider at Trumbull Loves Children, Inc. I understand that I must supply TLC with the prescribed medication in the original container dispensed properly labeled by a physician and a pharmacist. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order.

Name: ____ Relationship to Child: ______________

Address: ____ Telephone: ______________________

Parent/Guardian Signature: ____

The center is required to document and verbally tell parent or guardian of any errors in the administration of the above medication.

Date of error: ______________________________________ Time of error: _________________

Description of error: ____

Name of authorized provider who notified parent/guardian: _______________________________________

Time parent/guardian was notified: _____________________ Date: _______________________

Administration of Medication Record

Child's Name: ______________________________

Drug Name: ______________________ **Pharmacy and Prescription #**______________

Dosage Ordered: __________________ **Doctor's Name:** ______________________

Method of Administration: ______________________________

DATE ADMINISTERED	TIME ADMINISTERED	DOSAGE	SIGNATURE OF PERSON GIVING MEDICATION	COMMENTS

Before any medication is administered for the first time the following items must be in place:

☐ The authorization form is completed

☐ The medication is in a safety-cap container

☐ The original prescription label is on the medication container

☐ The name of the child is on the container

☐ The date on prescription is current (Within the expiration date for medications which are so labele

______________________________ ______________________________

Signature of Site Director or Assistant 1 Name of Site Director or Assistant 1

____

Date Received at Center