

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: _____

Relevant 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: _____