Community Action Opportunities
HELPING PEOPLE. CHANGING LIVES.

Nurse reviewed _____
Action plan reviewed _____ / _____
Medication expiration date _____

Phone Number: 828-252-2495 Fax: 828-254-4395

Permission to Administer Medication in Head Start Classroom

Documentation Codes: **AB**-Absent **ED**-Early Dismissal **D/C**- Medication Discontinued **NS**-No Symptoms **SC**-School Closed for Students

Child's Name:_____**DOB:**_____ **Name of Medicine:**_____
Dosage: _____ **Times to be Given: See Allergy Action Plan**_____ **Side Effects:** _____
Contraindications:_____ **Special Instructions:** _____
Physician's Signature: _____**Date:** _____**Valid for 1 year from:** _____ **to:**_____
Parent's Signature: _____ **Date:** _____**Valid for 6 months from:** _____**to:** _____

	Monday	Tuesday	Wednesday	Thursday	Friday
Medication name					
Dosage Given					
Time Given					
Date					
Staff Signature					
Observed Behaviors *Any Unusual behaviors must be reported immediately to child's parents and Head Start Health Services*					

Date	Medication Name	Amount Received	Previous on Hand	Total Amount Received+Previous	Delivered By	Received By

Parent's 6 months extension: Parent's Signature: _____ **Date:**_____ **Valid from:** _____**To** _____

(Doctor's signature is valid for 1 year. Parent's signature is valid for 6 months)

Revised:7/16