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 Asthma 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