Community Action Opportunities

HELPING PEOPLE. CHANGING LIVES.

Head Start

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

PERMISSION TO ADMINISTER MEDICATION IN HEAD START CLASSROOM

Child's Name ____________ Date of Birth ____________ Name of Medication ____________ Dosage ____________

Contraindications ____________ Times to be Given ____________ Side Effects ____________ Special Instructions

- ☐ See Asthma Action Plan
- ☐ See Allergy Action Plan
- ☐ See Seizure Action Plan

Physician's Signature ____________ Date ____________ Valid for one year from Date ____________ to Date ____________

Parent / Guardian Signature ____________ Date ____________ Valid for six months from Date ____________ to Date ____________

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

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Dosage Given					
Time Given					
Date					
Staff Signature					
Observed Behaviors (Unusual behaviors must be reported immediately to child's parents & HS Health Services)					

Date	Medication Name	Circle one	Amount	Previous on hand	Total Amount	Parent / Guardian Signature	Staff Signature
		Received / Returned					
		Received / Returned					
		Received / Returned					
		Received / Returned					
		Received / Returned					

Parent/Guardian 6 Months Extension Signature ____________ Date ____________ Valid for six months from Date ____________ to Date ____________

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