Minnesota Visiting Nurse Agency
3433 Broadway Street NE, Suite 300
Minneapolis, MN 55413

MEDICATION ADMINSTRATION RECORD

(A separate authorization is required for each medication)

I, _____, give permission for _____
Parent Child Care Center

to give _____ the following medication:
Full First & Last Name

Medication: _____

Amount/Dose: _____

Time of Dose/Frequency: _____

Route of administration: ❑Oral ❑Rectal ❑Topical ❑Inhaled ❑Eye/Nose/Ear ❑Other:_____

Start Date: _____ End Date: _____

Reason for Medication: _____

Possible Side Effects: _____

Physician Signature (for Over the Counter Medication): _____ **Date:** _____

Parents Signature: _____ **Date:** _____

For Staff to Complete

Give medicine **only** if you can answer **yes** to all questions below.

Is the Medication Administration Record complete?	❑ Yes	❑ No
Is the medication in a child-resistant container?	❑ Yes	❑ No
Is the original prescription label on the medication container?	❑ Yes	❑ No
Is the prescription current?	❑ Yes	❑ No
Is today's date before the expiration date?	❑ Yes	❑ No
Is the child's first and last name on the container?	❑ Yes	❑ No

Dose										
Date										
Time										
Initials										
Comments										

Dose										
Date										
Time										
Initials										
Comments										

Teacher's name (signature/initials)	Teacher's name (signature/initials)

Unused medication: Date returned to parents_____

Place this form in child's file when medication is finished.

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Parent Permission to Administer Medication and Log Form

Medication Administration Record

Dose	Date	Time	Given By	Comments