

**COASTAL COMMUNITY ACTION, INC.  
HEAD START/EARLY HEAD START**

**Request for Medication To Be Given During Day Care Hours – Pg. 1 of 2**

**To be completed by Physician: (Info should refer to one RX only,  
including PRN medications)**

**Name of child:** \_\_\_\_\_ **Center:** \_\_\_\_\_

**SSN:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Name of prescribed medication:**

\_\_\_\_\_

**Time(s) and dosage/strength to be given:**

<u>Dosage(s)</u>	<u>Time ( circle AM or PM )</u>
<u>#1</u> _____ ,	_____ <u>AM or PM.</u>
<u>#2</u> _____ ,	_____ <u>AM or PM.</u>
<u>#3</u> _____ ,	_____ <u>AM or PM.</u>

**To be given from (date)** \_\_\_\_\_ **to** \_\_\_\_\_

**Instructions for use of medication, including when medication should not be given:**

\_\_\_\_\_  
\_\_\_\_\_

**Diagnosis for which medication was prescribed:**

\_\_\_\_\_

**Possible side effects to be noted:**

\_\_\_\_\_  
\_\_\_\_\_

**Emergency**

**instructions:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**This medication will be furnished by parent/guardian within a container properly labeled by a pharmacist with identifying information (e.g., name of the child, medication dispensed, dosage prescribed, and the time it is to be given).**

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**DEA#** \_\_\_\_\_ **Physician's Telephone Number:** \_\_\_\_\_

\_\_\_\_\_

**Request For Medication To b Given During Day Care Hours – Pg. 2 of 2**

**Name of child:** \_\_\_\_\_ **Center:** \_\_\_\_\_  
**SSN:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Parent's Permission**

**I hereby give my permission for my child (named above) to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release Head Start/Early Head Start and their agents and employees from any and all liability that may result from my child taking the prescribed medication.**

**Parent/Guardian's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Telephone Number:**  
\_\_\_\_\_

**Name of Emergency Contact Person if Parent/Guardian cannot be reached:**

**Telephone Number:** \_\_\_\_\_

**Center Use only**

**Name and title of person(s) to administer medication:**

\_\_\_\_\_

**(Any questions or concerns will be brought to immediate attention of the Health Specialist.)**

**Center Manager's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**White copy – Child's Health File**

**Pink copy – Teacher**

**Yellow copy – Health Specialist**

\_\_\_\_\_