RisingOaks
Early Learning Ontario

Administration Record: Prescribed Medication(s)

Child's Name: _____ **Date of Birth** ____/____/_____
MM / DD / YYYY

Centre: _____ **Program Room:** _____

Storage Conditions:
☐ To Be Stored at Room Temperature ☐ To Be Stored in Refrigerator

Exact Storage Location: _____

Prescribed Medication	Expiry Date	Dosage	Time To Be Given	Date To	
				Start	Stop

Reason for prescribed medication(s) *(optional)*

_____

_____

I am the legal guardian of the child and have the authority to enter into this agreement. I authorize the administration of the above prescribed medication(s) by RisingOaks Early Learning, and am providing the above medication **in its original container**.

I understand and accept that if questions, arise about giving/applying the medication, RisingOaks Early Learning will contact the dispensing pharmacy to clarify the issue (i.e., when to be given/applied and how often).

I understand and accept that if problems arise with the giving/applying of the medication (e.g., refusal by child to take medication, side effects, or an allergic reaction) RisingOaks Early Learning will stop giving/applying the medication and will notify me.

I am aware that I must take home all medication each night except in the case of medications required for life threatening situations (e.g., anaphylaxis, febrile seizures, etc). These medications will be checked monthly by staff for expiration dates.

Tip: Use Tools>Fill & Sign to type or draw signature

_____ _____
Parent's Signature Date

Staff Acceptance of Medication	Date Received:	
☐ Form completed in full	Signature of Staff Accepting Medication ↓	
☐ Dose & Frequency requested match instructions on prescription label		

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Child's Name: _____ **Centre:** _____

Room: _____

DATE MM / DD / YY	PRESCRIBED MEDICATION	DOSAGE	TIME GIVEN (e.g., 10:00 am)	GIVEN BY	PARENT INITIALS