Medication Instructions & Agreement

School Year ___________________

Peace Early Learning Center ~ 5675 Field Street, Arvada, Colorado 80002 ~ ELC (303) 431-4494 ~ Fax (303) 940-7683

Reminder: Do not send sick children to the Early Learning Center. This form is for the exception where medication is needed for well children.

1. The following guidelines must be followed for your child to receive prescribed medication from staff at Peace Lutheran Early Learning Center.
2. Both parent/guardian and physician's signatures must be present on the Medication Agreement form.
3. Only physician-prescribed medication will be given by the Early Learning Center Staff. This includes over the counter drugs such as cough syrup, vitamins, Tylenol, Advil, etc.
4. Medication must be in its original container. The container must have a label with the following information:
   Child's Name, Physician's Name, Physician's Phone Number, Name of Medication, Dosage, Frequency of Dosage, Date the Medication Should Be Completed, Expiration Date of the Medication
5. The Early Learning Center staff will not assume giving of injectable medications under any circumstances. The only exception to this is when a child has a condition that is potentially life-threatening and an injection is ordered by a physician in order to save his or her life (such as an allergic reaction).
6. Please do not allow your child to carry the medication himself or herself. An adult must bring the medication in, along with the Medication Agreement Form. Medications will be kept under lock and key.

To Be Completed By Parent or Guardian

I hereby request and give my permission to Peace Early Learning Center to administer medication to my child. I understand that it is my responsibility to provide the medication in the original pharmacy labeled container. I also understand that the person administering the medication may not alter or change any medications from their original form (cut or half pills, etc). Any prescription changes will require an additional signed and completed Medication Agreement.

Name of Student: ______________________________ Date of Birth: ______________

Parent's Name: ___________________________ Medication: ____________________

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Signature of Parent or Guardian Date

To Be Completed By The Physician

Patient's Name: ____

Medication: ______________________________ Route: _________________

Purpose: ____________________________ Times to be Given: ________________

Dosage: ______________________ Continuous From _____________ to _____________

Possible Side Effects: ____

Name of Physician: ____

Fax Number: _______________________ Phone Number: _______________________

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Signature of Physician Date

The person giving the medication must put their initials and time on the medication log.

Medication Log for ______________________________

Medication: ______________________________

Initials	**Person Dispensing Medication**	**Date**	**Time**	**Dose Given**
			: AM / PM	
			: AM / PM	
			: AM / PM	
			: AM / PM	
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			: AM / PM	
			: AM / PM	
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