Medication Permission
Sequatchie Valley Head Start

This form must be completed and signed by both the parent and by the physician. It should be on file in the medication administration book before Head Start Staff can give the medication.

Name of child: _____
First Middle Last
Date of birth: _____ Center: _____

Hours that child attends the center: Child attends from _____a.m. to _____p.m.

Part A: Physician statement (to be completed by the child's physician).

The above named child requires the following medication to be given during Head Start center hours.

Name of Medication: _____

Dosage: _____

Time(s) to be given at the Head Start Center: _____

Route: _____by mouth _____by inhaler

_____by nebulizer _____other, please specify_____

Length of time medication will be given: _____

Possible side effects: _____

Other significant information: _____

Physician Signature: _____ **Date:** _____

Part B: Parent Permission (to be completed by child's parent or guardian)
During center operating hours, designated Head Start employees have my permission to give the medicine listed above to my child. I understand that all prescription medication(s) provided to the center should be provided on a daily basis (only one day's dose(s) sent each day), except for medicines for emergency use. Medicines needed for emergency use, such as an epipen for allergic reaction and medicines needed for treatment of an asthma attack, may be left at the center for use on an as needed basis. The medication must be handed over to Head Start employees by an adult and **never** in the hands of a child. I understand that prescription medicines must be in a pharmacy labeled container. Over the counter medicines must be labeled with the child's name and in the original container.

_____ _____
Parent or Guardian Signature **Date**

Head Start Staff: Be sure to fax a copy of this completed permission form to the Head Start office for the child's Head Start office record and notify the Health Manager.