CCL.026
Rev. 8/2013

Kansas Department of Health and Environment
Bureau of Family Health
Child Care Licensing Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 Fax: 785-296-0803
Website: www.kdheks.gov/kidsnet

Kansas
Department for Children and Families

Authorization for Dispensing Medications to Children or Youth
Short-Term Medications (Prescription and Non-Prescription)

Prescription medications must be in their original containers labeled with the child's or youth's first and last name, the date the prescription was filled, the name of the licensed physician or licensed nurse practitioner who wrote the prescription, the expiration date of the medication, and specific and legible instructions for administration and storage of the medication. Administer the medication according to the instructions. **Non-prescription medications** can be given by permission and direction from the parent, guardian or legal custodian based on general advice received from the child's or youth's physician. Administer nonprescription medication from the original container labeled with the first and last name of the child or youth and according to the instructions on the label.

Medication #1

First and Last Name of Child or Youth

Name of Medication

Reason for Medication

Dose Time to be Given Stop Date

Name of Licensed Physician/Nurse Practitioner prescribing the medication

(_____)_____
Phone number of Health Care Provider

I allow the above medication to be given to my child or youth by the child care provider/staff member or school age program staff member.

Parent's Signature Date

Medication #2

First and Last Name of Child or Youth

Name of Medication

Reason for Medication

Dose Time to be Given Stop Date

Name of Licensed Physician/Nurse Practitioner prescribing the medication

(_____)_____
Phone number of Health Care Provider

I allow the above medication to be given to my child or youth by the child care provider/staff member or school age program staff member.

Parent's Signature Date

THIS FORM IS TO BE USED TO DOCUMENT ADMINISTRATION OF ONLY THE MEDICATION(S) IDENTIFIED ABOVE. Provider or staff member to note any comments or remarks about the child's or youth's appearance on the back of this form.

Date mm/dd/yy	Time	Name of Medication	*Initials	Date mm/dd/yy	Time	Name of Medication	*Initials

Each person administering medication is to sign on the back side of this form and identify initials used above.

*Signature of Person Administering Medication _____ Initialing as_____

*Signature of Person Administering Medication _____ Initialing as _____

*Signature of Person Administering Medication _____ Initialing as _____

*Signature of Person Administering Medication _____ Initialing as _____

Note Form

Date	Comments about the incident or other related incidents, including remarks about the child's or youth's appearance.

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Authorization for Dispensing Medications to Children and Youth
Long-Term Medications (Prescription and Non-Prescription)

Prescription medications must be in their original containers labeled with the child's or youth's first and last name, the date the prescription was filled, the name of the licensed physician or licensed nurse practitioner who wrote the prescription, the expiration date of the medication, and specific and legible instructions for administration and storage of the medication. Administer the medication according to the instructions. **Non-prescription medications** can be given by permission and direction from the parent, guardian or legal custodian based on general advice received from the child's or youth's physician. Administer nonprescription medication from the original container labeled with the first and last name of the child or youth and according to the instructions on the label. A record of administration must be kept.

****Stop date not to exceed one year from the start date. A new authorization is to be completed any time the medication, dosage, times to be given, or instructions from the parent or health care provider change from the information included on this form. Additional copies of this form may be attached to this page if more space is needed to record the administration of the medication for up to one year if there are no changes in instructions. Above information must be completed on each page but the parent's signature is required only once per year.**

First and Last Name of Child or Youth

Name of Medication (only one medication per authorization) Prescription OR Non Prescription

Reason for Medication

Dose Time to be Given **Start Date** **Stop Date****

Name of Licensed Physician or Nurse Practitioner prescribing the medication Phone # of Physician

I allow the above medication to be given to my child or youth by the child care provider/staff member or school age program staff member.

Parent's Signature Date Signed

THIS FORM IS TO BE USED TO DOCUMENT ADMINISTRATION OF ONLY THE MEDICATION IDENTIFIED ABOVE. Provider or staff member to note any comments or remarks about the child's or youth's appearance and/or condition on the back of the form.

Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials

Each person administering medication is to sign on the back side of this form and identify initials used above.

*Signature of Person Administering Medication _____ Initialing as _____

*Signature of Person Administering Medication _____ Initialing as _____

*Signature of Person Administering Medication _____ Initialing as _____

*Signature of Person Administering Medication _____ Initialing as _____

Note Form

Date	Additional comments about the incident or other related incidents, including comments or remarks about the child's or youth's appearance and/or condition.