PYRAMID LAKE PAIUTE TRIBE
LITTLE WARRIORS
LEARNING CENTER

Nixon Center
195 W Pyramid Lake Road
(775) 574-1031

Wadsworth Center
380 Pyramid St.
(775) 575-2774

1.

Medication Administration Packet

Authorization to Give Medicine
PAGE 1 - TO BE COMPLETED BY PARENT/GUARDIAN

CHILD'S INFORMATION

□ Nixon Center □ Wadsworth Center

____/____/____
Today's Date

_____ ____/____/____
Name of Child (First and Last) Date of Birth

Name of Medicine _____

Reason medicine is needed during school hours _____

Dose _____ Route _____

Time to give medicine _____

Additional instructions _____

Date to start medicine _____/_____/_____ **Stop date** _____/_____/_____

Known side effects of medicine _____

Plan of management of side effects _____

Child allergies _____

PHYSICIAN'S INFORMATION

_____ _____
Prescribing Health Professional's Name Phone Number

PERMISSION TO GIVE MEDICINE

I hereby give permission for the facility/school to administer medicine as prescribed above. **I also give permission for the caregiver/teacher to contact the prescribing health professional about the administration of this medicine. I have administered at least one dose of medicine to my child without adverse effects.**

_____ _____
Parent or Guardian Name (Print) Parent or Guardian Signature

_____
Home Phone Number Work Phone Number Cell Phone Number

Receiving Medication

PAGE 2 - TO BE COMPLETED BY CHILD CARE PROVIDER

Name of child _____

Name of medicine _____

Date medicine was received _____/_____/_____

Safety Check

☐ 1. Child-resistant container.

☐ 2. Original prescription or manufacturer's label with the name and strength of the medicine.

☐ 3. Name of child on container is correct (first and last names).

☐ 4. Current date on prescription/expiration label covers period when medicine is to be given.

☐ 5. Name and phone number of licensed health care professional who ordered medicine is on container or on file.

☐ 6. Copy of Child Health Record is on file.

☐ 7. Instructions are clear for dose, route, and time to give medicine.

☐ 8. Instructions are clear for storage (eg, temperature) and medicine has been safely stored.

☐ 9. Child has had a previous trial dose.

10. Is this a controlled substance? Y ☐ N ☐ If yes, special storage and log may be needed.

☐ I have prepared a dosage sheet and alerted staff.

_____

Caregiver/Teacher Name (Print)

_____

Caregiver/Teacher Signature

Medication Log

PAGE 3 - TO BE COMPLETED BY CHILD CARE PROVIDER

Name of child _____

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____
Dosage/amount					
Route					
Staff signature					

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____
Dosage/amount					
Route					
Staff signature					

Describe error/problem in detail in a Medical Incident Form. Observations can be noted here.

Date/time	Error/problem/reaction	Action Taken	Name of parent/guardian notified and time/date	Caregiver Initials

RETURNED / DISPOSED	Date	Parent/guardian signature	Caregiver/teacher signature