Child Has Allergies
☐ YES ☐ NO

Tender Care
Learning Centers
The Early Education Professionals

AUTHORIZATION FOR MEDICATIONS OR MEDICAL TREATMENT TO BE ADMINISTERED DURING CHILD CARE CENTER HOURS

THIS FORM MUST BE SUBMITTED BI-ANNUALLY FOR EACH MEDICATION OR TREATMENT, REGARDLESS WHETHER PRESCRIPTION OR NON-PRESCRIPTION.

a) Medications must be in an original container and labeled by the pharmacy as follows:
- -Child's Name
- -Name and Dosage of Medication
- -Expiration Date of Medication
- -Authorized Prescriber's Name
- -Name & Phone Number of Pharmacy
- -Over the counter medication must be in original container and labeled with child's full name

b) Parents must notify Tender Care Learning Centers personnel in writing if a medication or treatment is discontinued.

c) A new form must be submitted for any dosage, condition or time change.

d) Medication will be destroyed if not picked up within one week following termination of the order

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THIS SECTION TO BE COMPLETED BY THE PARENTS OR GUARDIANS

Child's Name_____ Date of Birth_____ Sex _____

Parent or Guardian name: _____

Address_____ Phone number: _____

Emergency Contact Name and Phone _____

I REQUEST THAT MY CHILD BE ASSISTED IN TAKING MEDICATION OR UNDERGOING THE MEDICAL TREATMENT DESCRIBED BELOW AT TENDER CARE LEARNING CENTERS BY AUTHORIZED PERSONS.

In consideration of Tender Care Learning Centers granting our request to dispense certain medications, or administer certain medical treatments to our child,_____(child's name),

we_____, and _____(parent or guardian names), the undersigned parents and/or guardians, on our own behalf and on behalf of our minor child, hereby release, indemnify and hold harmless the Tender Care Learning Centers and its current or former employees, owners and/or Directors, from and against any and all claims, damages, actions or causes of action (except those arising under the American With Disabilities Act) resulting in, arising out of, or connected directly or indirectly with the request for or the administering of the medication and/or treatment described on the next page to our child. We understand that Tender Care staff members who administer medication have been trained in compliance with applicable regulations, but that they have not necessarily received formal medical or nursing training in diagnosis or in administration of medications or other medical treatment. Our authorized prescriber has advised us that formal training or nursing training is not necessary to perform the services requested. We assume all risks arising out of our request.

We acknowledge that Tender Care Learning Centers will accommodate in terms of striving to provide the dispensing of medication or other treatments pursuant to the directions provided by our authorized prescriber where required during learning center hours. We understand that Tender Care reserves the right to cancel any such services where Tender Care determines that continuation could result in undue risk, disruption or hardship on the center or its staff or students, except where prohibited by law (for example the Americans With Disabilities Act). Any such cancellation shall be preceded by as much advance notice as is reasonable under the circumstances.

☐ I have administered at least one dose of the medication listed above with the exception of emergency medications without adverse side effects.

Witness Signature	Parent/Guardian Signature	Date
Witness Signature	Parent/Guardian Signature	Date

AUTHORIZED PRESCRIBER TO COMPLETE THIS SECTION

Diagnosis for which medication/treatment is given during childcare hours: _____

_____

Name of prescription or non-prescription medication/complete description of treatment: _____

_____

Form of medication and dosage (specific instructions as to how medication should be given)_____

_____

If medicine/treatment is to be administered daily, at what time? _____

If medicine/treatment is to be given WHEN NEEDED, describe indications: _____

Is this a Controlled Drug? _____

How soon can it be repeated? _____

Is the child authorized to medicate/treat herself/himself? _____

Length of time this treatment is required: From: _____to _____

Is the child taking any other medication that could have an adverse reaction to this medication or treatment?_____

Precautions, adverse reactions and plan for management if occur:_____

Restriction of activity:_____

Detailed Instructions:_____

_____

_____

CERTIFICATION OF PHYSICIAN

I certify that the treatments/medications described above must be provided to the child while at the child care center, and that the foregoing medications/treatments may be provided by child care personnel who do not have medical or nursing training.

AUTHORIZED PRESCRIBER _____ TELEPHONE_____

ADDRESS _____

AUTHORIZED PRESCRIBER SIGNATURE: _____ DATE:_____