BRIGHT HORIZONS
AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

MEDICATION TYPE:

❒ **PRESCRIPTION** ❒ **NON-PRESCRIPTION** ❒ **TOPICAL OINTMENT**

I have read the *Policy on Administering Medications and Ointments* and I hereby authorize Bright Horizons agents to administer the following medication to my child:

Child's Name: _____

- **Prescription Medications:** must have a current pharmacist's label that includes the child's full name, dosage, current date, times to be administered, and the name and telephone number of the physician.
- **Oral Non-prescription Medications:** require a written order from the child's medical provider and the parent/guardian specifying the product, dosage, time, start date and end date and reason for a period not to exceed ***one week***.
- **As Needed Children's Medications:** require a written order from the child's medical provider and the parent/guardian for a period not to exceed ***6 months***. Authorization must list the reason, dosage, start date and end date.
- **Non-prescription Topical Children's Ointments:** can be applied with authorization from the parent/guardian according to manufacturer's instructions for a period not to exceed ***one year.*** This includes diaper cream, sunscreen and insect repellant and other non-medicated (free from antibiotic, antifungal or steroidal components) topical ointments designated for use for children.
- **Non-prescription Topical Children's Ointments:** require a written order from the child's medical provider and parent/guardian to be applied to ***open, oozing sores***. Authorization must list the reason, dosage, start date and end date.
- **Medications for Chronic Illnesses**: require a written order from the child's medical provider and parent/guardian. Authorization for prescription medications will not exceed the period indicated on the prescription label; however, will not exceed ***one year***. Non-prescription medications must have a written order from the medical provider and parent/guardian; list the reason, dosage, times of administration, start date and end date, for a period not to exceed ***one year***.
- **Diaper Cream, Sunscreen and Insect Repellant:** can be applied with authorization from the parent/guardian according to manufacturer's instructions for a period not to exceed ***one year***. Directions must be designated for use for children.

Note: Products containing Benzocaine, the main ingredient in over-the-counter (OTC) gels and liquids applied to the gums or mouth to reduce pain, may only be applied with authorization from the child's medical provider for a period not to exceed ***seven consecutive days***.

Note: All medications must be provided in the original container, labeled with the child's full name and any medication spoon/device to administer the medication must be provided. Non-prescription medications must be designated for use for children.

I further agree to indemnify and hold harmless Bright Horizons Children's Centers LLC, and their agents and servants, against all claims as a result of any and all acts performed under this authority and according to the instructions below.

Medication: _____

Administration Route: _____

Reason for Medication: _____

Medication Storage: _____

Side Effects_____

Dosage:_____

Six Rights of Medication

1. **Verification that the *right* child receives**
2. **The *right* medication**
3. **In the *right* dose**
4. **At the *right* time**
5. **By the *right* method**
6. ***And the right* documentation is completed**

Times of Administration: _____ _____ _____ _____

Start Date: _____ End Date: _____

Physician's Name: _____ Physician's License Number: _____

Physician's Signature: _____

Parent/Guardian Signature: _____

MEDICATION PERMISSION AND INSTRUCTIONS

CHILD CARE HOMES AND CENTERS

Department of Licensing and Regulatory Affairs

Bureau of Community and Health Systems

Child Care Licensing Division

If you are giving or applying any medication to a child in care, the following must be completed by the parent for **each** medication. An interruption in medication will require a new permission form.

TO BE COMPLETED BY PARENT

I give my permission for _____ to give or apply the medication
(Caregiver, Facility)

_____ , to my child _____ , as follows:
(Specify, prescribed medication/over the counter product) (Child's Name)

DIRECTIONS:

1. Date to Begin Giving Medication	2. Date to Stop Medication
3. Times Medication is to be Given	4. Amount (dosage) of Medication Each Time Given
5. Storage of Medication	
6. Other Directions, if Any	
Signature of Parent	Date

TO BE COMPLETED BY THE CAREGIVER GIVING THE MEDICATION:

DATE	TIME	AMOUNT GIVEN	CAREGIVER'S NAME	CAREGIVER'S SIGNATURE

It is recommended this form be reviewed with the parent every 3 months if the medication is ongoing.