CDC
CHILD DEVELOPMENT CENTER
PO Box 1117 1602 W. Ferguson Rd
Mt. Pleasant TX 75455
(903)575-2092 fax (903)575-2077

Year: _____

Medication Administration

Child's name/*Nombre del Niño*	Birthday/*Fecha de Nacimiento*	Room/Salón

To Administer a Prescription Medication:

- The medication must be in its ORIGINAL container, with a legible label from the pharmacy indicating child's name, date, name of medication, dosage, instruction for use, doctor's name, pharmacy name and telephone number.
- Medications will only be given if prescribed 4 times a day due to the overwhelming number of medications. If medication can be given at home or other than during school hours, CDC/ EHS are not obligated to administer it.
- Medications are to be given only to the child indicated on the label (siblings cannot share).
- A separate authorization is required for EACH MEDICATION and EACH EPISODE of illness.
- As needed medication will only be given if symptoms are present.
- A Medication Administration Record (MAR) will be kept for each child receiving medication at school.

Name of medication/*Nombre del medicamento*: _____

Reason for giving medication/*Razon para dar medicamento*: _____

Dosage/*Dosis*: _____ Time of last dose/Tiempo de ultima dosis: _____

Time(s) to be given at school/*Tiempo que se va a dar en la escuela*: _____

[Circle] Route: by mouth, inhalation, eye (R/L), ear (R/L), skin-location_____. Other _____
[Señale con un circulo] *Ruta: por la boca, inhalar, Ojo (d/I) Oido (d/ I), en la piel-ubicación*_____. Otro_____

Possible side effects/*Posible efectos secundarios*: _____

Prescribing Physician's Name/*Doctor quien receto el medicamento*: _____
Phone/*Numero de telefono*: (_____) _____

Special handling/ storage instructions/*Como mantener y guarde el medicamento*: _____

Refrigeration/ *Refrigeracion*: YES/ NO *SI/NO*

I request and authorize the Child Development Center staff to administer the above named medication to my child./*YO requiero y autorizo al personal del Centro De Desarrollo Infantil a administrar la medicina nombrada arriba para mi hijo (a).*

Parent or Guardian Signature/*Firma del Padre o Tutor*: _____ Date: _____

Parent Phone Number/*Numero de Telefono*: _____ Date: _____

Release of medication at end of day/Liberacion de medicamento al final del dia

Keep at School/*Mantener en la escuela* _____ Give to Bus Driver/*Mandar en el autobus* #_____

Parent will pick up/*Padres recogeran la medicina* _____

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Medication Administration Record

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Date	Time Given	Medication Name	Safety Check	Dosage Given	Route	Staff Signature	Behavior Changes