Bright Starts
Co-operative Early Learning Centre Inc.

Administration of Prescribed and Non-Prescribed Medications Form

Child's Name:	**D.O.B.(dd/mm/yr):**	**Sex:** Female
Address:	**City:**	**Postal Code:**
Telephone Numbers: Home:	**Work:**	**Cell:**
Dispensing Pharmacist:	**Phone Number:**	

Medications Prescribed/Non-Prescribed	**Dosage**	**Time Given**	**Date To**	
			Start	**Stop**

Reason for Prescribed/ Non-Prescribed Medication:

_____

_____

_____

I authorize the administration of the above prescribed or non-prescribed medication by Bright Starts Co-operative Early Learning Centre Inc. (Bright Starts CELC), and I am providing the above medication **in its original container.**

I understand and accept that if questions arise about giving/applying the medication, Bright Starts CELC will contact the dispensing pharmacy to clarify the issue i.e. when to be given/applied and how often.

I understand and accept that if problems arise with the giving/applying of the medication i.e. refusal by child to take medication, side effects, or an allergic reaction, Bright Starts CELC will stop giving/applying the medication and notify me.

_____ _____

Parent Signature **Date**

Child Medication Log

Child's Name: _____

Date	Medication	Dosage	Time Given	Given By	Witness

Complete _____ (please ✓ once medication has been completed and place form in child's file)