NO MEDICATION WILL BE ADMINISTERED WITHOUT A SIGNED AUTHORIZATION FORM…NO EXCEPTIONS

JUMPSTART CHILD ENRICHMENT CENTER
5765 NW 151 Street
Miami Lakes, FL 33014
License #C11MD1923
305-826-0555

AUTHORIZATION FOR PRESCRIPTION & NON-PRESCRIPTION MEDICATION

TO BE COMPLETED ON A "*DAILY*" BASIS IF MEDICATION(S) IS TO BE DISPENSED DAILY. (NO EXCEPTIONS!!!). NOTE: THIS AUTHORIZATION FORM IS ONLY VALID FOR THE DATE AS INDICATED ABOVE. A NEW AUTHORIZATION FORM MUST BE COMPLETED ON A DAILY BASIS BY PARENT/LEGAL GUARDIAN ONLY.

No medication shall be given by Jumpstart Child Enrichment Personnel without the signed permission of Parent or Legal Guardian ONLY. All medication(s) MUST be in the original container with the child's name, name of physician, medication name, and medication directions written on the printed label.

Non-prescription medication brought in by the parent or legal guardian can only be dispensed if there is written authorization from the parent or legal guardian only. Medication which has expired or is no longer being administered shall be returned to the parent or legal guardian only.

NOTE: NO MEDICATION SHALL BE DISPENSED WITHOUT A COMPLETED AND SIGNED AUTHORIZATION FOR MEDICATION FORM. (NO EXCEPTIONS!!!)

IF FIRST DOSAGE OF CHILD'S MEDICATION IS DUE TO BE DISPENSED WITHIN ½ HOUR OF CHILD'S ARRIVAL FIRST DOSAGE IS TO BE DISPENSED BY PARENT PRIOR TO DROPPING CHILD OFF IN HIS/HER CLASSROOM. THEREFORE, PREVENTING A DELAY IN DISPENSING MEDICATION. MEDICATION WITH "AS NEEDED" INDICATED WILL NOT BE DISPENSED.

Child's Name:_____ D.O.B.: _____ Age: ___ Class/Teacher: _____
Name of Medication:_____

Exact Amount of Medication to be given:_____

Time(s) Medication is to be given:_____

RECORD OF MEDICATION(S) TO BE DISPENSED

Complete Name of Medication:_____

Date & Time:	Amount:	Employee Initials:	Comments:

Name of Medication:_____

Exact Amount of Medication to be given:_____

Time(s) Medication is to be given:_____

RECORD OF MEDICATION(S) TO BE DISPENSED:

Complete Name of Medication:_____

Date & Time:	Amount:	Employee Initials:	Comments:

NOTE: THIS AUTHORIZATION FORM IS ONLY VALID FOR THE DATE AS INDICATED ABOVE. A NEW AUTHORIZATION FORM MUST BE COMPLETED ON A DAILY BASIS BY PARENT/LEGAL GUARDIAN ONLY.

THIS FACILITY IS MONITORED BY DCF AND THE FLORIDA DEPARTMENT OF HEALTH WHICH REQUIRE THE USE OF THIS FORM FOR ALL MEDICATIONS (PRESCRIPTION OR OVER THE COUNTER) THAT ARE DISPENSED WHILE YOUR CHILD IS IN THE CARE OF THIS FACILITY.

I hereby give written permission to Jumpstart Child Enrichment Center to dispense the medication(s) listed above in accordance with the written directions printed on the prescription or manufacturer's label.

Date:_____ Parent's/Legal Guardian's Signature:_____
(A copy of signed form to be retained on file for a minimum of 4 months)