

Ashburn Village Country Day School

AUTHORIZATION TO ADMINISTER MEDICATION

Child's Name: _____ Date: _____

Child's Age: _____ Classroom: _____ Teacher: _____

- Medication will only be administered by an employee who is certified in medication administration. If there is no employee certified in MAT present in the building the medication will not be administered.
- The Authorization to Administer Medication form must be signed by the parent/guardian.
- Medication will be administered ONLY in accordance with the written consent for each medication. All medications must accompany this form – except long-term medications.
- Medication must have the child's name, medication name, dosage amount and time to be administered needs to be listed on the original container with the prescription label attached.
- Medications are ONLY to be given at approximately 11:00 AM and/or 3:00 PM only, and for a ***maximum duration of 10 working days***, unless the child suffers from a federally protected disabling condition – which requires the completion of IHP & Asthma Companion Medication Authorization form.
- Any medication left at the school past the authorization date or which have expired will be returned to the parent or discarded.

Medication Name: _____ Expiration Date of Medicine: _____

Reason child is taking medicine: _____

Dosage to be Given: _____ Route: _____

Circle times of administration: 11:00AM 3:00PM

Authorization effective until: _____ (please write in date)

Special Instructions: _____

Ashburn Country Day School has permission to administer the medication listed above to my child.

Parent / Guardian Signature: _____ Date: _____