

Parent Medication Administration Checklist (5 rights review)

(Each line must be checked (✓) BEFORE medication can be accepted and administered to your child)

- 1. Is your child's full name, date of birth and address filled in?

- 2. Does the name of the medication listed on the medication authorization form match exactly to the name of the medication that you bring into the center? Please ask your health care provider to write the brand and generic name of the medication, the strength of the medication and the side effects.

- 3. The dose of the medication. This is the amount of medication that the child care provider will be giving your child.

Please note: if this is a liquid medication, you must provide a tool to administer the medication, such as a calibrated medicine cup, dosing spoon or syringe. Please ensure that the dose that is written on the medication form is measurable on the dosing tool, for example if the order states to give 2.5 ml, please ensure that your medicine cup has "2.5 ml"

- 4. Route: this should indicate if the medication is to be given by mouth, into eyes, ears, inhaled, etc.

- 5. Time: If the medication is to be given at an exact time please make sure the provider authorization identifies the exact time. If the medication is to be given if the child experiences specific symptoms (prn- as needed), please make sure that the provider authorization identifies why the child should receive the medication.

For example: if the child receives an inhaler for asthma, please list the specific symptoms that the teacher will notice that will be clearly alert them that the child requires medication.

If the child has an EpiPen® or Auvi-Q®, the correct time to administer the EpiPen® or Auvi-Q®, is per the emergency health care plan.

TEACHERS: (1) Please make sure the above items have been read and checked off by parent/guardian. (2) Please read the above items including the 5 Rights of Medication Administration.

By signing this form, we acknowledge that we have read and understand the above, including the 5 Rights of Medication Administration.

Teacher Name: _____ Signature: _____ Date: _____

Parent/Guardian: _____ Signature: _____ Date: _____