



**Dalhousie  
Community  
Association**

**DALHOUSIE OUT OF SCHOOL CARE**

**MEDICATION ADMINISTRATION FORM**

**NOTE:** *Early Learning and Child Care Regulation 10 (1): A license holder may administer or allow the administration of medication or other health care to a child only where (a) the written consent of the child’s parent has been obtained, and (b) in the case of medication, (i) the medication is in the original labelled container, and (ii) the medication is administered according to the labelled directions. \*\*\*The Dalhousie Out of School Care Program will ONLY administer medication prescribed by a Doctor.*

Today’s Date: \_\_\_\_\_  
MONTH/DAY/YEAR

Name of Child: \_\_\_\_\_ D.O.B.: \_\_\_\_\_  
LAST FIRST MONTH/DAY/YEAR

Name of Medication: \_\_\_\_\_

Reason for Medication: \_\_\_\_\_

Dosage Amount: \_\_\_\_\_ Time/Frequency: \_\_\_\_\_

**\*\*\*Any changes to the “Dosage Amount” and/or “Time/Frequency” will require a NEW Form to be filled out\*\*\***

Route of Administration:

- Oral
- Topical
- Inhaled
- Injection (Epi-pen)
- Other (please explain) \_\_\_\_\_

Signs and/or Symptoms:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Is this a “Short-Term” OR “Long-Term” Medication?** (Please circle one)

**NOTE:** *For Short-Term Medications, please follow the instructions based on the prescription label indicated by the physician. Verify that the parent/guardian’s First Dose MATCHES the Start Date, then calculate the End Date to correspond with the Label.*

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
MONTH/DAY/YEAR MONTH/DAY/YEAR MONTH/DAY/YEAR



I authorize The Dalhousie Out of School Care/Preschool personnel to administer the medication named above to my child in the manner as stated. I release any liability in relation to the administration of this medication. I also acknowledge that I, the parent/guardian, have given the first dose of this medication without any allergic or unexpected reactions.

Parent/Guardian's Name: \_\_\_\_\_  
LAST FIRST

Parent/Guardian Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_  
MONTH/DAY/YEAR

**NOTE: Follow all instructions outlined by the Health Care Provider and Parent/Guardian. Ensure that ALL 7 Sections are COMPLETE before administering the medication and ALWAYS have a second staff member on duty to witness. Only Staff Members with Childcare Certification (Level 2 or 3) AND Valid First Aid/CPR are permitted to Administer Medication. If there is no qualified Staff Member to administer the medication, the DOSC Director MUST be contacted! Lastly, please ensure that all medication is stored according to the prescription label.**

Name of Medication	Time/Date Last Dose was Given by Parent/Guardian	Date Given by Staff (M/D/Y)	Time Given by Staff	Dose Given by Staff	Staff Initials	Witness Initials

**Emergency Contact Information**

Name	Relationship	Cell Phone Number	Work Phone Number