Gottlieb Memorial Hospital

A Member of Trinity Health

Gottlieb Child Development Center
905 W. North Avenue, Entrance #17
Melrose Park, IL 60160
708-538-6871

Medication Authorization Form

Child's Name: ______________________ Date of Birth: ______________

MEDICATION TYPE: ☐ PRESCRIPTION ☐ NON-PRESCRIPTION

All medication must be provided in the original container, labeled with the child's full name. Where applicable, the implement for proper measurement must be provided and labeled with the child's full name. If not provided, medication cannot be administered. Non-prescription medications must be designated for use for children on the label.

I have read the *Medication Administration Policy* in the Family Guide and I hereby authorize Gottlieb Staff to administer the following medication to my child.

Prescription Medications: must have a current pharmacist's label that includes the child's full name, dosage, current date, times to be administered, and the name and telephone number of the physician.

Non-prescription Medication: with written authorization from parent/guardian can be administered according to the manufacturer's instructions for up to five days per month. Written authorization from the child's medical provider is required for any administration exceeding 5 days per month or deviation in manufacturer's instructions.

Standing Orders: with written authorization from the child's medical provider may be administered according to physician's instructions for a period not to exceed six months. Authorization must list the reason, dosage, instructions, start date and end date.

Medications for Chronic Illnesses: require a health care plan completed by the child's medical provider for a period not to exceed one year. Must include complete medication administration information, otherwise a completed Medication Authorization Form signed by medical provider is required (See Prescription and Non-prescription medication above for details).

Homeopathic/Herbal/Homemade Medications: may be administered for up to **1 year** with physician authorization.

Note: Products containing Benzocaine, the main ingredient in over-the-counter (OTC) gels and liquids applied to the gums or mouth to reduce pain, may only be applied with authorization from the child's medical provider.

On behalf of myself, my family, and my minor child, I hereby release and agree to defend, hold harmless, and indemnify Gottlieb Memorial Hospital, its subsidiaries, affiliates, and employees, from any and all claims of injury or damage (including personal injury) as a result of any and all acts performed under this authority and according to the instructions below.

Medication: ______________________ Administration Route: ______________

Reason for Medication: ______________________ Medication Storage: ______________

Dosage: ____

Times of Administration: __________ __________ __________ __________

Start Date: ______________________ End Date: ______________________

Side Effects: ____

Parent/Guardian Signature: ______________________________ Date: __________

Physician's Name: ______________________ Physican's License Number: __________

Physician's Signature: ______________________________ Date: __________