PLADEC DAY CARE

Pladec Mack
349 Mack Street
Kingston, ON
K7L 1R4
Phone: 613-546-1234
Fax: 613-546-6152
Email: mack@pladecdaycare.ca

Pladec East
671 Innovation Drive
Kingston, ON
K7K 7E7
Phone: 613-507-4321
Fax: 613-507-5678
Email: east@pladecdaycare.ca

DRUG/MEDICATION ADMINISTRATION INFORMATION AND CONSENT FORM

ALL sections are to be completed by parent/guardian of a child who is requesting that a drug or medication be administered during hours that child receives child care, in accordance with the child care centre's medication administration policy and procedures

One for each medication

Cough suppressants, Pain and Fever Reducers are NOT permitted

Child's First & Last Name: _____

Full Name of Medication to be administered: _____
Physician's Name: _____
Reason for Medication: _____
Date of Purchase or Date Dispensed: _____
Expiry Date: _____
Authorized Start Date: _____
Authorized End Date (or ongoing): _____
Storage Instructions: _____
Full names of other medications child is taking: _____
Side effects to be aware of: _____

Schedule of Administration

☐ The drug or medication needs to be administered according to the following schedule:
Time(s) of day to be given at centre: _____
Dosage/Amount: _____
Method of administration: _____
Other instructions: _____

☐ The drug or medication needs to be administered when the following physical symptoms are observed:
_____
Amount/Dosage: _____
Method of Administration: _____

Parent/Guardian Authorization Statement:

I hereby authorize the staff or Pladec Day Care Centre to administer the above-named drug or medication to my child and handle the drug or medication in accordance with the procedures I have provided on this form.

I understand that expired drugs or medications will not be administered to my child at any time in accordance with Pladec's medication administration policy.

I Understand that staff at Pladec are not medically trained to administer drugs and medications.

_____	_____	_____
Date:	Parent/Guardian Printed Name	Parent/Guardian Signature

FOR STAFF USE ONLY

Confirm all areas of this form have been filled out, the medication is in its original packaging and the dose matches the prescription. Provide form to supervisor by the end of the day for review

Location of medication will be stored: _____

Received By: _____ Reviewed By: _____
Date/Staff Signature Date/Supervisor Signature:

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DRUG/MEDICATION ADMINISTRATION TRACKING SHEET

Date	Time	Dosage Administered	Full Name of Staff	Signature	Comments or Observations (including symptoms of illness)

End Date of Medication: