RisingOaks
Early Learning Ontario

Consent to Administer Medication

Child's Name ______________________ **Date of Birth** ______________________

Centre ______________________ **Program** ______________________

Storage Conditions ☐ Room Temperature ☐ Fridge

Storage Location ______________________

1. Reason for medication(s) (e.g., teething, febrile seizures)

2. Type	3. Drug Name	4. Expiry Date	5. Administration Start Date	6. Administration Stop Date
☐ Prescribed ☐ Over the Counter				

7. Frequency (e.g., every 4 hr)	8. Dosage	9. Time(s) to Give	10. Symptoms to Preclude Administration of Non-Prescription, As Needed Medication (e.g., fever > 100° F or 37.7° C, wheezing, etc)

Important Notes:

- One form per medication. Boxes 1 to 8 and either box 9 or 10 must be completed. Please print (or type)
- For Start and Stop Dates: If medications are for life-threatening situations (e.g., asthma) you may indicate "ongoing " or "PRN", if applicable. If so, you must list the specific symptoms that would preclude or warrant administration of the medication.
- MEDICATION MUST BE IN THE ORIGINAL PACKAGING WITH FULL INSTRUCTIONS.
- Dosage is by age unless a doctor's note or prescription is provided stating exact dosage.

Acknowledgement

I am the legal guardian of the child and have the authority to enter into this agreement. I authorize the administration of the above medication by RisingOaks Early Learning, and am providing the above medication **in its original container with the noted expiry date or with full prescription label**. I understand and accept that if questions, arise about giving/applying the medication, RisingOaks Early Learning may contact a pharmacy to clarify the issue (i.e., when to be given/applied and how often).

I understand and accept that if problems arise with the giving/applying of the medication (e.g., refusal by child to take medication, side effects, or an allergic reaction) RisingOaks Early Learning will stop giving/applying the medication and will notify me.

I am aware that I must take home all medication each night except in the case of medications required for life threatening situations (e.g., anaphylaxis, febrile seizures, etc). These medications will be checked monthly by staff for expiration dates. By typing or signing below, you are indicating your Consent and Agreement to these terms.

______________________ ______________________

Parent's Signature Date

Tip: Use Tools>Fill & Sign to draw or type your signature. Electronic signatures, including typing your name in the Parent Signature box will bind this agreement.

Staff Acceptance of Medication

Date Received: ______________________

Signature of Staff Accepting Medication

☐ Form completed in full

☐ Dose & Frequency requested match instructions on bottle for the age of the child or

☐ confirmed by Doctor's Note

(2023-03)

This document is available in alternate formats and/or with communication supports, upon request. This agreement may be signed in a number of counterparts and facsimile signatures are acceptable and deemed binding. We protect and respect your privacy. Your personal information is used only for the purposes stated on or indicated by the form. For complete details, see our Privacy Statement at www.risingoaks.ca or contact your centre Supervisor for a copy.

RisingOaks
Early Learning Ontario

Administration Record: Medication

Child's Name: ______________________ **Centre** ______________________ **Room** ____________

DATE MM / DD / YY	MEDICATION	SYMPTOMS	TIME PARENT CONTACTED, BY WHOM?	DOSAGE	TIME GIVEN	GIVEN BY	PARENT INITIALS
		☐ N/A	☐ N/A				
		☐ N/A	☐ N/A				
		☐ N/A	☐ N/A				
		☐ N/A	☐ N/A				
		☐ N/A	☐ N/A				
		☐ N/A	☐ N/A				
		☐ N/A	☐ N/A				
		☐ N/A	☐ N/A				
		☐ N/A	☐ N/A				
		☐ N/A	☐ N/A				
		☐ N/A	☐ N/A				

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