RisingOaks
Early Learning Ontario

Consent to Administer Non-Prescription Medication(s)

Child's Name: ____________________ **Date of Birth** ____/_____/______
MM / DD / YYYY

Centre: ______________________ **Program Room:** ________________________

Storage Conditions: ☐ To Be Stored at Room Temperature ☐ To Be Stored in Refrigerator

Exact Storage Location: ____

Non-prescription Medication	Expiry Date	Dosage	Frequency Allowed (e.g., every 4 hr)	Specific Times or Symptoms to Preclude Administration (e.g., fever > 100° F or 37.7° C, febrile seizure, etc)	Date to Start	Date to Stop

If medications are for life-threatening situations or infant pain relief, you may Indicate "ongoing " or "PRN", if applicable

If additional medications are brought in on a different date, please start a new form.

Reason for non-prescription medication(s)

(e.g., teething, febrile seizures)

____

____

I am the legal guardian of the child and have the authority to enter into this agreement. I authorize the administration of the above non-prescription medication(s) by RisingOaks Early Learning, and am providing the above medication **in its original container with the noted expiry date**. 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) or pain reliever for infants (e.g., Infant Tylenol). These medications will be checked monthly by staff for expiration dates. I understand that RisingOaks will contact me prior to administering non-prescription medications that are left on site to be used on an as needed basis when no specific times or start and stop dates have been given.

Tip: Use Tools>Fill & Sign to type or draw signature

______________________________ ____________________
Parent's Signature Date

Staff Acceptance of Medication	Date Received:	
☐ Form completed in full	Signature of Staff Accepting Medication ↓	
☐ Dose & Frequency requested match instructions on bottle for the age of the child or ☐ confirmed by Doctor's Note		

(2020-12)

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.

Administration Record: Non-Prescription Medication(s)

Child's Name: ___________________________ **Centre:** _____________ **Room:** _________________

DATE MM / DD / YY	NON-PRESCRIPTION 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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