MEDICATION ADMINISTRATION FORM

<table>
<thead>
<tr>
<th>Healthcare Provider please complete &amp; sign:</th>
<th>Medication1</th>
<th>Medication 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis:</td>
<td></td>
<td></td>
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<tr>
<td>Medication:</td>
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<tr>
<td>When to use</td>
<td></td>
<td></td>
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<tr>
<td>(e.g., symptoms, time of day, frequency, etc.)</td>
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<tr>
<td>Route of delivery:</td>
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<tr>
<td>(e.g., by mouth)</td>
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<tr>
<td>Dose of medication:</td>
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<tr>
<td>Duration of time child needs to be on this medication:</td>
<td></td>
<td></td>
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<tr>
<td>Possible side effects:</td>
<td></td>
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<tr>
<td>Special Instructions/Precautions</td>
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</tbody>
</table>

Healthcare Provider’s Signature: ________________________________ Date: __________

Parent or Guardian: I give permission to Head Start/Early Head Start staff to administer the above prescribed medication, if needed during class, to my child according to the instructions listed above by my child’s Health Care Provider. I will inform Head Start/Early Head Start of any changes in my child’s condition, treatment, or medication.

Doy permiso al personal de Head Start para que administren la medicación arriba prescrita, si es necesitada durante clase, a mi niño según las instrucciones enumeradas arriba por el Proveedor del Cuidado Médico de mi niño. Comunicaré a Head Start cualquier cambio en la condición, tratamiento, y medicación del niño.

Parent /Guardian/ Padre/Guardian: ___________________________ Date: ______

To be completed by the Center staff. Plan has been reviewed by:

Teacher/Specialist: ___________________________ Date: __________
(Sign & Print)

TA/secondary administer: ___________________________ Date: __________
(Sign & Print)

Site Manager: ___________________________ Date: __________
(Sign & Print)

If primary or secondary administrators are unavailable, trained staff are authorized to administer medication.