CCL.026 Rev. 5/2020

Kansas Department of Health and Environment

Bureau of Family Health Child Care Licensing Program 1000 SW Jackson, Suite 200 Topeka, KS 66612-1274

Phone: 785-296-1270 Fax: 785-559-4244 Website: www.kdheks.gov/kidsnet



Authorization for Dispensing Medications to Children and Youth Short-Term Medications (Prescription and Non-Prescription)

Prescription medication must be in their original containers labeled with the child's/youth's first and last name; the name of the licensed physician, physician assistant (PA), or advanced practice registered nurse (APRN) who ordered the medication; the date the prescription was filled; the expiration date of the medication; and specific, legible instructions for administration and storage of the medication. Administer the medication only to the child/youth designated on the prescription label in accordance with the instructions on the label. **Non-prescription medications** can be given with written permission and direction from the parent or legal guardian. Administer nonprescription medication from the original container labeled with the first and last name of the child/youth and according to the instructions on the label.

		Medication	1#2	
First and Last Name of Child/You	uth Date of Birth	First and La	ast Name of Child/Youth	Date of Birth
Name of Medication		Name of M	edication	
Reason for Medication		Reason for	Medication	
Dose Time to be Given	Stop Date	Dose	Time to be Given	Stop Date
Name of Licensed Physician/PA the medication () Phone Number of Physician, PA I allow the above medication to be g by the designated person.	, or APRN	the medica (censed Physician/PA/APR tion _)	PRN
Parent's Signature	Date	Parent's Si	gnature	Date

Date mm/dd/yy	Time	Name of Medication	*Initials	Date mm/dd/yy	Time	Name of Medication	*Initials

*Signature of Designated Person Administering Medication		Initialing as		
*Signatur	e of Designated Person Administering Medication	Initialing as		
*Signatur	e of Designated Person Administering Medication	Initialing as		
	Note Form			
Date	Additional comments about the incident or other	rolated incidents, including		
Date	comments or remarks about the child's/youth's a			

*Signature of Designated Person Administering Medication _____

Initialing as_____