*For Ibuprofen/Tylenol/Etc

CCL.359
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Kansas Department of Health and Environment
Bureau of Family Health
Child Care Licensing Program
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Kansas
Department of Health and Environment

Authorization for Self-Administration of Medication (Children/Youth in School Age Programs)

According to K.A.R. 28-4-590(e)(5)(A) any operator may permit a child or youth with a **chronic illness, condition requiring prescription medication on a regular basis, or a condition requiring the use of an inhaler** to administer the medication under staff supervision. The operator shall obtain written permission for the child or youth to self-administer medication from the child's or youth's parent or other adult responsible for the child or youth, and from the licensed physician or nurse practitioner treating the condition of the child or youth. Prescription medications must be in their original containers labeled with the child's or youth's first and last name, the date the prescription was filled, the name of the licensed physician or licensed nurse practitioner who wrote the prescription, the expiration date of the medication, and specific and legible instructions for administration and storage of the medication. A record of administration must be kept.

First and Last Name of Child or Youth

Name of Medication (only one medication per authorization)

Reason for Medication

Dose Time to be Given **Start Date** **Stop Date****

Print the Name of licensed Physician or Nurse Practitioner prescribing the medication Phone# of Health Care Provider

I authorize the self-administration of the above medication by my child or youth under staff supervision.

Signature of Parent or Responsible Adult **Date Signed**

I authorize the self-administration of the above medication by the child or youth listed above under staff supervision.

Licensed Physician or Nurse practitioner Signature **Date Signed**

****Stop date not to exceed one year from the start date. A new authorization is to be completed any time the medication, dosage, times to be given, or instructions from the parent or health care provider change from the information included on this form. Additional copies of this form may be attached to this page if more space is needed to record the administration of the medication for up to one year if there are no changes in instructions. Above information must be completed on each page but the parent's signature and the licensed physician or nurse practitioner signature is required only once per year.**

THIS FORM IS TO BE USED TO DOCUMENT SELF ADMINISTRATION OF ONLY THE MEDICATION IDENTIFIED ABOVE. Provider or staff member supervising the self-administration of medication to note any comments or remarks about the child's or youth's appearance and/or condition on the back of the form.

Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials

Each person administering medication is to sign on the back side of this form and identify initials used above.

*Signature of Person Supervising Self-Administration of Medication _____ Initialing as _____

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*Signature of Person Supervising Self-Administration of Medication _____ Initialing as _____

Note Form

Date	Additional comments about the incident or other related incidents, including comments or remarks about the child's or youth's appearance and/or condition.