WEST END HOME CHILD CARE SERVICES

1411 Bloor Street West, Toronto, Ontario M6P 3L4 • Tel: (416) 537-4154 • Fax: (416) 537-4154

Medication Form

Only doctors prescribed medicine, or non-prescribed medicine accompanied by doctor's note.

(*Children's Tylenol, Advil etc.*.) will be administered to children.

I _____hereby with _____ authorization, give my
(Parent's name) (Doctors name)

permission for West End Home Child Care provider to administer to my child _____
Child's name

the following medication, according to the doctor's direction at the rate and amount as listed:

1.) _____ _____ _____ from _____ to _____
Medicine amount times per day date date

2.) _____ _____ _____ from _____ to _____
Medicine amount x per day date date

3.) _____ _____ _____ from _____ to _____
Medicine amount x per day date date

_____
Parent/ Guardian signature

Medicine Name	Date	Amount	time	initials	Medicine Name	Date	Amount	time	initials

If child is absent, please mark <u>A</u>
Any unused medication must be sent home.
Providers must attach complete medication forms to monthly attendance sheet.
Medication forms must be kept in file for three years.

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ONGOING MEDICATION FORM

PARENT CONSENT FORM FOR MEDICATED TOPICAL CREAM

I, _____ hereby, give my permission West End Home Child Care provider to
(Parent's name)
administer the following cream(s)

_____
(cream name)

_____ on my child _____
(Child's Name)

As needed for _____
(indicate need)

_____ _____
Date Parent Signature

Please indicate below the dates and times given daily

DATE	TIME	Initials	DATE	TIME	Initials	DATE	TIME	Initials

If child is absent, please mark A

Providers must attach complete medication forms to monthly attendance sheet.
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ONGOING MEDICATION FORM

PARENT CONSENT FORM FOR SELF ADMINISTRATION MEDICATION

I, _____ hereby, give my permission for my child to self administer the

following medication: _____
(medication name)

_____ on my child _____
(Child's Name)

As needed for _____
(indicate need)

_____ _____
Date Parent Signature

Please indicate below the dates and times given daily

DATE	TIME	Initials	DATE	TIME	Initials	DATE	TIME	Initials

If child is absent, please mark A

Providers must attach complete medication forms to monthly attendance sheet.
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ONGOING MEDICATION FORM

PARENT CONSENT FORM TO ADMINISTER EPI-PEN MEDICATION

I, _____ hereby, give my permission for Provider or Family Member to

administer the following medication _____
(medication name)

To my child _____
(Child's Name)

As needed for when my child is exhibiting the following symptoms_____

_____

Initial where applicable [box]

☐ I have completed an Anaphylaxis Action Plan.

☐ I have trained Provider and or Family Member to administer EPI-PEN.

☐ School-age. (My child carries their EPI-PEN on person and is capable of Self-Administration of own EPI-PEN.

_____ _____
Date Parent Signature

Please indicate below the dates and times given.

DATE	TIME	Initials	DATE	TIME	Initials	DATE	TIME	Initials

Providers must attach complete medication forms to the monthly attendance sheet.
Medication forms must be kept in file for three years.