BRIGHT HORIZONS FAMILY SOLUTIONS

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

MEDICATION TYPE:

❒ **PRESCRIPTION** ❒ **NON-PRESCRIPTION** ❒ **TOPICAL OINTMENT**

I have read the *Policy on Administering Medications and Ointments* and I hereby authorize Bright Horizons agents to administer the following medication to my child:

_____.

- Prescription medications must have a written order from the physician (may include the label on the medication).
- Non-prescription medication to be used for more than three days requires a written order from the child's physician.
- Duration of non-prescription topical ointments' authorization cannot exceed 90 days.

I further agree to indemnify and hold harmless Bright Horizons Family Solutions, and their agents and servants, against all claims as a result of any and all acts performed under this authority.

Medication: _____ Dosage: _____

Side Effects: _____ Time of Administration: _____

Number of Days: _____ Date: _____

Physician's Name: _____ Physician's Number: _____

Physician's Signature: _____

Parent/Guardian Signature: _____

MEDICATION LOG (to be completed by medicine administrator)

MEDICATION	DOSAGE	TIME	DATE	SIGNATURE

Keep completed *Authorization for Administration of Medication* forms in the child's file.