

**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:

Child's Name: \_\_\_\_\_

- Prescription medications must have a written order from the physician.
- 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.
- Duration of as needed medications require a written order from the child's physician and 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 and according to the instructions below.

**Five Rights of Medication**

Medication: \_\_\_\_\_

1. Verification that the *right* child receives
2. The *right* medication
3. In the *right* dose
4. At the *right* time
5. By the *right* method

Administration Route: \_\_\_\_\_

Reason for Medication: \_\_\_\_\_

Side

Effects \_\_\_\_\_

\_\_\_\_\_

Dosage: \_\_\_\_\_

Times of Administration: \_\_\_\_\_

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Physician's Number: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_