BRIGHT HORIZONS

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 current pharmacist's label that includes the child's full name, dosage, current date, times to be administered, and the name and telephone number of the physician.
- **Non-prescription Children's Medication:** can be administered for up to ***three consecutive days*** according to the manufacturer's instructions with written authorization from the parent/guardian Written authorization from the child's medical provider is required to continue use beyond the three consecutive days.
- **Non-prescription Topical Children's Ointments:** can be applied with authorization from the parent/guardian according to the manufacturer's instructions for a period not to exceed ***one year.*** This includes diaper cream, sunscreen and insect repellant designated for use for children.
- **Non-prescription Topical Children's Ointments:** can be applied to **open, oozing sores** for up to ***three consecutive days*** according to the manufacturer's instructions with written authorization from the parent. Written authorization from the child's medical provider is required to continue use beyond the three consecutive days or if the condition worsens.
- **As Needed Children's Medications:** require written authorization from the child's medical provider for a period not to exceed ***six months***. Authorization must list the reason, dosage, start date and end date.
- **Medications for Chronic Illnesses**: require a written order from the child's medical provider for a period not to exceed ***one year***.

Note: Products containing Benzocaine, the main ingredient in over-the-counter (OTC) gels and liquids applied to the gums or mouth to reduce pain, may only be applied with authorization from the child's medical provider for a period not to exceed ***seven consecutive days***.

Note: All medications must be provided in the original container, labeled with the child's full name and any medication spoon/device to administer the medication must be provided. Non prescription medications must be designated for use for children.

I further agree to indemnify and hold harmless Bright Horizons Children's Centers LLC, 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.

Medication: ____

Administration Route: ______________________________________

Reason for Medication: _____________________________________

Medication Storage: ____

Six Rights of 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**
6. ***And the right* documentation is completed**

Side Effects:

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Dosage: ____

Times of Administration: ____________ ____________ ____________ ____________

Start Date: ______________________ End Date: ______________________

Physician's Name: ______________________ Physician's Number: ______________________

Physician's Signature: ____

Parent/Guardian Signature: ______________________ Date: ______________________