

**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 (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 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: _____

Side

Effects _____

Dosage: _____

Times of Administration: _____

Start Date: _____ End Date: _____

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

Physician's Signature: _____

Parent/Guardian Signature: _____