

**EFMP RESPITE CHILD CARE AUTHORIZATION FOR MULTIPLE MEDICATION ADMINISTRATION**

<b>Name:</b>	Date of Birth:	Home Address:	Home Phone Number:	Last Updated:
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**Allergies to Medications:**

CURRENT MEDICATION REGIMENT					
MEDICATION	PURPOSE	DOSAGE	FREQUENCY/TIME	DURATION	POSSIBLE SIDE EFFECTS
1.					
2.					
3.					
4.					
5.					
6.					
7.					

**AUTHORIZATION FOR MEDICATION ADMINISTRATION**

I hereby authorize, respite care provider, \_\_\_\_\_, to administer the above medications, to my child, \_\_\_\_\_.  
 I further agree to indemnify and hold harmless this provider, his/her agents, and servants against all claims of any acts performed under this authority.

Parent/Guardian Name	Parent/Guardian Signature	Phone Number
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**Medication in Respite Care:**

1. Requires parent/guardian to complete and sign this *Authorization for Medication Administration*; form shall be kept in the child's file with all supportive documentation.
2. Medication must be in original, child-proof container and labeled with child's name.
3. Requires a written plan to record the administration of all medications and to inform the child's parent/guardian daily when medications have been given.

**Prescription Medications:**

1. Medication is administered with the pharmacy label directions as prescribed by the child's health care provider.
2. The instructions from the child's parent/guardian shall not conflict with the label directions as prescribed by the child's health care provider.