Use this form for all prescription medications.

Community United Child Care Centers, Inc
Child Development Centers – Administration Office
1026 E Seerley Blvd, Cedar Falls, IA 50613
(319) 277-7303, (319) 277-0472 fax

PRESCRIPTION MEDICATION RELEASE
(HEALTH CARE PROVIDER AND FAMILY AUTHORIZED)

rev 02/19/18

To be completed by health care provider:

Child's full name: ____ Date of Birth: _____/_____/_____

Medication: ____

Dose: ________________________________ Frequency: __________________________________

Start Date: ________/______/______ End Date: ________/______/______

Health Care Provider Printed Name and Phone Number: ____

Health Care Provider Signature: ____ Date: _____/_____/_____

To be completed by family:

Date medication brought to center: _______/_____/______ Amount in container: ____________________________

Time(s) to administer: __________________________

I give permission to CUCCC to administer medicine as prescribed above. **I also give permission for the caregiver/teacher to contact the prescribing health professional about the administration of this medicine. I have administered at least one dose of medicine to my child without adverse effects.**

Parent/Guardian signature: ____ Date: _____/_____/_____

DATE	**TIME**	**MEDICATION**	**MEDICATION NEEDED?** (Circle)	**REASON** (Write symptom or circle no symptom or absent)	**DOSAGE**	**OFFICE STAFF INITIALS**
/ /	:		Needed Not Needed	Symptoms: No symptoms present Absent		
/ /	:		Needed Not Needed	Symptoms: No symptoms present Absent		
/ /	:		Needed Not Needed	Symptoms: No symptoms present Absent		
/ /	:		Needed Not Needed	Symptoms: No symptoms present Absent		
/ /	:		Needed Not Needed	Symptoms: No symptoms present Absent		
/ /	:		Needed Not Needed	Symptoms: No symptoms present Absent		
/ /	:		Needed Not Needed	Symptoms: No symptoms present Absent		

Must fill out for child during timeframe indicated above **each time you do or do not** give the child medication. Turn into office after the end date indicated above. Additional sheets can be added to reach the end date without additional health care provider and family signatures.

PD/APD Signature: ____ ` Date: ____/____/____

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PD/APD Signature: ____`______________ Date: ____/____/______