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*** with a written order from the parent/guardian according to the manufacturer's instructions. 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 and other non-medicated (free from antibiotic, antifungal or steroidal components) topical ointments 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. This includes diaper cream, sunscreen and insect repellant and other non-medicated (free from antibiotic, antifungal or steroidal components) topical ointments designated for use for children. Written authorization from the child's medical provider is required to continue use beyond *three* consecutive days or if the condition worsens.
- **As Needed Children's Medications:** require a written order 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***. (See Prescription and Non-prescription medication above for details)

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.

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**

Medication: _____

Administration Route: _____

Reason for Medication: _____

Medication Storage: _____

Side Effects _____

Dosage: _____

Times of Administration: _____ _____ _____ _____

Start Date: _____ End Date: _____

Physician's Name: _____ Physician's Signature _____

Physician's Number: _____ Prescription Number: _____

_____ _____

Parent/Guardian Signature Date