MEDICATION ADMINISTRATION PROCEDURE
NESD Head Start

In the event a routinely scheduled medication must be given at Head Start, the Health Services Coordinator must be notified. Staff will receive training in administrating the medication from the Health Service Coordinator or from a trained person.

The following procedure will be followed:

1. The form "Medication Administration" must be signed by the physician and the parent. A copy of the signed form will also be sent to the Health Coordinator for a record of the doctor and parent's signatures.

2. The "Medication Administration" form will list the name of the medication, the reason, dosage, time and the route of administration.

3. Medications must be kept in the original container with the prescription on the container matching the physician's order.

4. The parent will bring the medication and the form with the doctor and parent signatures to the Center. A staff person, or the parent, will be assigned to administer the medication. Parents will be responsible to notify staff of any changes in a child's medication.

5. Medications will be kept in a locked container, with the exception of emergency medications (i.e. Epi-Pen, inhaler). Emergency medications will be stored where quickly accessible to staff, but out of children's reach. The log will be completed immediately after the medication has been given to the child. The "Medication Form" must be kept with the medication and in the child's file at the center.

6. Wash hands before and after administering medication.

7. In the event that a child refuses medication or is uncooperative, the parent must be notified that the dose was not administered.

8. A monthly parent contact is required and will be documented on the log.

9. If an emergency medication (bee sting, asthma, food allergy) is needed, refer to the Emergency Medication Procedure.

MEDICATION ADMINISTRATION
NESD HEAD START

200 S. Harrison #1
Aberdeen, SD 57401
229-4506
Fax 226-0196

Name of Child _____ DOB _____

Name of Parent _____

Address _____

Medication _____Reason_____

For how long?_____ Dosage_____

Time _____Route_____

Possible side effects or additional comments:
_____

_____

Physician Signature_____Date_____

I authorize the Head Start staff to administer medication to my child.

Parent Signature _____ Date _____

12/12

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Child's Name_____

Administered by_____

DATE	TIME	ADMINISTERED BY	COMMENTS*	PARENT CONTACT (DATE/COMMENTS)**

*Any changes in child's behavior that may indicate medication side effects will be noted in the comments section and discussed with the parents immediately.

**Monthly contact is required with the parent/guardian for follow-up discussion. 12/12