# Authorization For Medication Administration

I, ________________________________________(print) hereby authorize designated agents of The Lighthouse Center for Infants to administer the following medication, prescription, non-prescription, creams, ointments, gels and sunscreen to my child, _________________________________________ (print). *Please ask for additional forms for the various medicinal needs of the child. I further agree to indemnify and hold harmless The Lighthouse Center for Infants, their agents, and servants against all claims as a result of any and all acts performed under this authority.

Child's Physician & Phone Number: ___________________________________________
Child's condition: ___________________________________________________________
Name of medication: ________________________ Rx Number: ____________________
Purpose of medication: _______________________________________________________
__________________________________________________________________________
__________________________________________________________________________
Time of administration: _______________________________________________________
Duration of medication: _______________________________________________________
Method of administration: _____________________________________________________
__________________________________________________________________________
Possible side effects: _________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
Name of Pharmacy & Phone Number: _________________________________________
Address of Pharmacy: _______________________________________________________
In case of emergency, First Contact: __________________________________________

Parent / Guardian Signature ________________________________________
Today's Date____________

**The following form must be completed before the administration of inhaled medicines. NEBULIZER CARE CONSENT/VERIFICATION (LIC 9166 (2/01) ALL MEDICATIONS WILL BE RECORDED ON CHILD'S INDIVIDUAL Medication records on each child shall be maintained for at least one year. All medications, prescription and non-prescription*