

**VACA-PLAYDAYS
MEDICATION RECORD FOR SHORT TERM MEDICATIONS**

(Those requiring administration for ten days or less)

Name of child: _____ Date of birth: _____ Sex: _____

Parent/guardian: _____ Home phone: _____ Work phone: _____

Other persons, if any, to be notified in case of emergency if parent/guardian is unavailable:

Name: _____ Phone/Beeper: _____

Allergies: _____

Other medications student is currently receiving (if not a violation of confidentiality): _____

I give permission for the VACA-PLAYDAYS director or a VACA-PLAYDAYS staff member to give the following medication to my son/daughter:

Medication: _____ Dose: _____ Route: _____ Times to be given: _____ Duration: _____

Special notes: _____

Diagnosis (if not a violation of confidentiality) : _____

Prescribing physician: _____ Date of order: _____

Signature of parent/guardian: _____ Date: _____

**MEDICATION ADMINISTRATION PLAN
(Completed by VACA-PLAYDAYS staff)**

Quantity of medication received _____ In properly labeled container? ___yes ___no

Potential side effects/adverse reactions: _____

Required storage: _____ Delegated to: _____

Plan for field trips, if applicable: _____

The above information is correct and the medication label has been reviewed.

VACA-PLAYDAYS Director

Date

SHORT TERM MEDICATION DAILY LOG

Date			
Time/Signature			

Directions: Initial with times of administration. A complete signature and initials of each person administering medication is documented on the reverse side.