EFM RESPITE CARE
AUTHORIZATION FOR MEDICATION ADMINISTRATION

Child's Name:	Date of Birth:
Allergies to Medications:	

CURRENT MEDICATION REGIMENT

MEDICATION	PURPOSE	DOSAGE	FREQUENCY/TIME	DURATION	POSSIBLE SIDE EFFECTS
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

I hereby authorize, my authorized respite care provider(s) to administer the above medications, to my child Listed above. I further agree to indemnify and hold harmless this provider, his/her agents, and servants against all claims of any acts performed under this authority.

Parent/Guardian Name	Parent/Guardian Signature	Date
Parent/Guardian Name	Parent/Guardian Signature (I confirm the above is still valid)	Date (Year 2)
Parent/Guardian Name	Parent/Guardian Signature (I confirm the above is still valid)	Date (Year 3)

Medication to be given during EFM Respite Care:

- Must be in original, child-proof container and labeled with child's name.
- Requires the use of the Administration Log for all medications along with the child's parent/guardian initials daily when medications are given.
- Administered with the pharmacy label directions as prescribed by the child's health care provider.
- Instructions from the child's parent/guardian shall not conflict with the label directions as prescribed by the child's health care provider.