



EFMP RESPITE CARE
AUTHORIZATION FOR OVER-THE-COUNTER MEDICATION ADMINISTRATION

Child's Name:			Date of Birth:		
Allergies to Medications:					
CURRENT MEDICATION REGIMENT – ALL SECTIONS MUST BE COMPLETED PER MEDICATION					
MEDICATION	PURPOSE	DOSAGE	FREQUENCY/TIME	DURATION	POSSIBLE SIDE EFFECTS
1.					
2.					
3.					
4.					
<p>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.</p> <div style="display: flex; justify-content: space-between; margin-top: 20px;"><div style="width: 30%;"><p>_____</p><p>Parent/Guardian Name</p></div><div style="width: 30%;"><p>_____</p><p>Parent/Guardian Signature</p></div><div style="width: 30%;"><p>_____</p><p>Date</p></div></div> <p style="text-align: center; margin-top: 20px;">MEDICAL PROVIDER</p> <p>Please review and check each statement before signing below:</p> <div style="margin-left: 20px;"><p>☐ I have reviewed the above medication administration request by the parent /guardian of the child.</p><p>☐ The medication is available over-the-counter and can be given as recommended on the label.</p><p>☐ For medication that does not provide the exact dosage on the label, I have recommended the above based on the child's age and weigh and concur with the above regiment.</p></div> <div style="margin-top: 20px;"><p>Medical Provider Signature: _____ Date: _____</p><p>Printed Name /Stamp <i>Required if hand signing</i></p></div>					