community education
AT PARKLAND COLLEGE

Medication Intake Form

THIS PAGE TO BE COMPLETED by Community Education Staff

Name of Child: _____

Name of Medicine: _____

Date Medicine was Received ____/____/____

Safety Check

☐ 1. Child-resistant container.

☐ 2. Original prescription or manufacturer's label with the name and strength of the medicine.

☐ 3. Name of child on container is correct (first and last names).

☐ 4. Current date on prescription/expiration label covers period when medicine is to be given.

☐ 5. Name and phone number of licensed health care professional who ordered medicine is on container or on file.

☐ 6. Copy of Camper Information Form has been submitted.

☐ 7. Instructions are clear for dose, route, and time to give medicine.

☐ 8. Instructions are clear for storage (eg, temperature) and medicine has been safely stored.

☐ 9. Child has had a previous trial dose.

Y ☐ N ☐ 10. Is this a controlled substance? If yes, special storage and log may be needed.

_____

Youth Program Manager Name (Print)

_____

Youth Program Manager (Signature)

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Medication Log

THIS PAGE TO BE COMPLETED by Community Education Staff

Name of child _____ Weight of child _____

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____
Dosage/amount					
Staff signature					

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date	/ /	/ /	/ /	/ /	/ /
Actual time given	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____
Dosage/amount					
Staff signature					

Describe error/problem in detail in a Medical Incident Form. Observations can be noted here.

Date/time	Error/problem/reaction to medication	Action taken	Name of parent/guardian notified and time/date	Caregiver/teacher signature

RETURNED to parent/guardian	Date	Parent/guardian signature	Caregiver/teacher signature
	/ /		
DISPOSED of medicine	Date	Caregiver/teacher signature	Witness signature
	/ /		

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Medication Incident Report

Date of report _____

Name of person completing this report _____

Signature of person completing this report _____

Child's name _____

Date of birth _____ Class ID/Name _____

Date incident occurred _____ Time noted _____

Person administering medication _____

Prescribing health care provider _____

Name of medication _____

Dose _____ Scheduled time _____

Describe the incident and how it occurred (wrong child, medication, dose, time, or route?)

_____

_____

_____

Action taken/intervention _____

Parent/guardian notified? Yes _____ No _____ Date _____ Time _____

Name of the parent/guardian that was notified _____

Follow-up and outcome _____

Staff member's signature _____