



**DOD IN-HOME CHILD CARE FEE ASSISTANCE
AUTHORIZATION FOR MEDICATION ADMINISTRATION**

Child's Name:	Date of Birth:
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Allergies to Medications:	
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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 in-home child care provider 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 DoD In-Home Child Care Fee Assistance:

- 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.