BRIGHT HORIZONS
AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

MEDICATION TYPE:
☐ PRESCRIPTION  ☐ NON-PRESCRIPTION  ☐ TOPICAL OINTMENT

I have read the Policy on Administering Medications and Ointments and I hereby authorize Bright Horizons agents to administer the following medication to my child:

Child’s Name: ________________________________________________________________

- Prescription medications must have a written order from the physician (and the medication spoon/device to administer the medication).
- Non-prescription medication to be used for more than three consecutive days requires a written order from the child’s physician (and the medication spoon/device to administer the medication).
- Duration of non-prescription topical ointments’ (authorized for use for children) authorization cannot exceed 90 days with a parent’s/guardian’s signature unless the ointment is a designated diaper cream or sunscreen authorized for use for children which in both cases can be authorized for one year.
- Duration of as needed medications require a written order from the child’s physician and cannot exceed 90 days.
- Ongoing medications’ (nebulizers, insulin, allergy meds) authorization cannot exceed 6 months.

I further agree to indemnify and hold harmless Bright Horizons Children’s Centers LLC, and their agents and servants, against all claims as a result of any and all acts performed under this authority and according to the instructions below.

Medication: ____________________________________________

Administration Route: _____________________________________

Reason for Medication: _______________________________________

Medication Storage: ______________________________________

Side Effects________________________________________________________________________
_______________________________________________________________________________

Dosage: ________________________________________________________________________

Times of Administration: __________       ____________        ____________          ____________

Start Date: ______________________________ End Date: ____________________________

Physician’s Name: _______________________       Physician’s Number: __________________

Physician’s Signature: __________________________________________________________

Parent/Guardian Signature: _____________________________________________________

Five Rights of Medication
1. Verification that the right child receives
2. The right medication
3. In the right dose
4. At the right time
5. By the right method