



# Rhode Island Department of Human Services

## All Providers: Medication Administration & Parental Consent for Medication

Updated 2/5/2026

### Important Information

A child who must take medication during child care hours is required to have a medication request completed and returned to the provider. New requests must be filled out by the parent/guardian each time a new medication is to be administered.

Prescribed and non-prescribed (over the counter) medication must not be administered to a child without:

- Written permission from the parent/guardian; and
- Written order from a licensed physician, physician's assistant, or nurse practitioner (which may include the label on the medication) indicating that the medicine is for a specified child.

**The written order includes the name of the child, name of the medication, circumstances under which it may be administered, route, dosage, and frequency of administration.**

*For School Age children (enrolled in Kindergarten or older) who self-carry rescue medication (prescription inhalers and/or auto-injectable epinephrine), there must also be medical documentation that the rescue medication has been prescribed and that the child needs to carry it on his or her person due to a medical condition.*

### Authorization

To be completed by the parent/guardian – **all information is required.**

Child's Name:		<b>Route</b> <input type="checkbox"/> Mouth <input type="checkbox"/> Eye: (Right / Left) <input type="checkbox"/> Nose: (Right / Left) <input type="checkbox"/> Ear: (Right / Left) <input type="checkbox"/> Skin <input type="checkbox"/> Other: _____
DOB:		
Medication:		
Refrigerated:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dosage:		
Schedule:		
Start Date:		<input type="checkbox"/> Physician Ordered  Physician Name: _____
End Date:		
Reason for medication:		

I authorize the following program \_\_\_\_\_

*Provider/Program Name*

to administer the following prescription medication or over-the-counter medication to the child named here. In addition, I will provide a list of potential side effects, obtained at the pharmacy, for prescription medications. The medication I am providing is clearly label in it's original container.

\_\_\_\_\_  
Parent/Guardian (Print)

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

