RECORD OF MEDICATIONS ADMINISTERED

	Name of Medication	Dosage	Time Given	Comments/Side Effects	Caregiver Initials
Sunday					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					

Authorization to Administer Prescription Medication

I _____ hereby authorize _____
Parent (print) Caregiver's Name

to give my child _____ _____ according to the written
Child's Name Medication
directions of a Physician.

_____ _____
Date Signature of Parent

Reason for Medication: _____

_____

Authorization to Administer Non-Prescription Medication

Please give _____ _____ at
Child's Name Medication and Dosage

_____ for _____
Time(s) Period of Time

_____ _____
Date Signature of Parent

Reason for Medication: _____