Permission to Administer Medication

Child's Full Name: ____

Program Level/Class: ____

Name of Medication/Reason needed:

1.____

2.____

Was medication given at home this morning? Yes______ (Time given: _________) No _____

Does medication need to be in the refrigerator? Yes______________ No _________________

Dosage: ____

Times to be given: _______________________am/pm _____________________________am/pm

Name of prescribing doctor: _____________________ Phone Number: ___________________

Parent signature giving authorization to dispense the medication:

____ Date: ____________________

PLEASE READ THIS NOTE

THIS AUTHORIZATION IS GOOD FOR ONE WEEK ONLY (MON-FRI)*

NEXT WEEK YOU WILL NEED A NEW AUTHORIZATION FORM