PERMISSION TO ADMINISTER MEDICINE

Child's name: _____________________________________Birthdate:_______________
Classroom:____

Allergies:__________________________________ Include food and/or medication allergies:
____

Doctor's Name: ______________________________ Doctor's Phone Number: _____________________

Medication #1

Name of Medication: ____

Dosage: ____

Time medication is to be given: __________________________Start Date: ________ End Date: _______

Purpose of medication: ____

Special instructions: ____

Possible side effects/Reactions: ____

Medication #2

Name of Medication: ____

Dosage: ____

Time medication is to be given: __________________________Start Date: ________ End Date: _______

Purpose of medication: ____

Special instructions: ____

Possible side effects/Reactions: ____

I, ____ hereby give permission for my child to receive the above medication, according to the listed directions and cautions, from the Child Care Director, or the Child Care Director designee. I confirm that I have given at least one dose of the medication without any evidence of side effects or adverse reactions. I understand that it is my responsibility to provide the medication in its original container and labeled with my child's full name. I am also to supply the appropriate measuring device needed to give the accurate dose of the medicine. I authorize the Director or Director Designee to contact the pharmacist or health care provider for more information about this drug, if necessary. I also authorize the Director or the Director's Designee to contact the health care provider regarding my child's health, if necessary.

Signature of Parent/Guardian ____ Date: _________________