Over-the-Counter
or
Prescription

Permission VALID: From _ _/_ _/_ _ _ _ To _ _/_ _/_ _ _ _

MEDICATION ADMINISTRATION PERMISSION & RECORD

Information about the child and the medicine
(Completed by parent/guardian)

Child's Name			Child's Date of Birth	
Medicine Expiration Date:	Time	Date	Dosage	Route
Special Instruction:				
Possible Reactions:				
Prescribing provider:		Phone:		
Pharmacy:		Phone:		
I give authorization to give medicine and to call the health care provider if needed. Parent/Guardian signature			Date	

RETURNED to Parent/Guardian	Date	Parent/Guardian signature	Child Care Staff signature
DISPOSED of Medicine	Date	Child Care Staff signature	Witness signature