PERMISSION TO ADMINISTER MEDICATION

Date: ______________________________

Child's Name: ______________________________ **Program:** ____________________

Name of Medication: ____
(must be original container with the pharmacy label):

Prescription No: ______________ Amount to Administer:___________________

Times to Administer: _________________________

Dates to Administer: from ____________ to ____________ Total Number of Days:_______

Possible Side Affect of Drug To Be Administered: _____________________________________

____

Instructions for Storage: ____

I ______________________________ authorize ____________________________ to
(Name of Parent/Guardian) (Name of Head Teacher/Teacher

administer the above medication to my child _____________________, as indicated.
(Name of Child)

____
Signature of Parent/Guardian

Record of Administration of Medicine

Date	Time	Program Director or Designate (Print Name After Signature)

September 2007

Record of Administration of Medicine (Additional Page)

Date	Time	Program Director or Designate (Print Name After Signature)