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 Program Teachers to administer the above
(Name of Parent/Guardian)

medication to my child ________________________________, as indicated.
(Name of Child)

____
Signature of Parent/Guardian

Record of Administration of Medicine

Date	Time	Program Teacher (Signature)

Record of Administration of Medicine (Additional Page)

Date	Time	Program Teacher (Signature)