



## Permission to Administer Medication Form

Child's Name:		Child's Date of Birth:	
Medicine:	Time(s) to be given:	Date(s) to be given:	Dosage:
Expiration Date:			
Medical Condition:			
Criteria for giving the medication:			
Administration (choose one) <input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Suppository <input type="checkbox"/> Other: _____		Special Instructions (Attach additional sheets as needed):	
		Special Conditions (Refrigerate, take with liquids, shake well, etc.):	
Possible Reactions:			
Prescribing Provider:		Phone:	
Pharmacy:		Phone:	
Best Person to call for Clarifications:		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