PERMISSION TO ADMINISTER MEDICATIONS

DATE:_____

I hereby give permission to:_____to
(NAME OF FACILITY)

administer:_____
NAME OF MEDICATION PRESCRIPTION NUMBER (if applicable)

to my child:_____

- ☐ according to the doctor's orders and instructions as noted on the prescription bottle or vial (for prescription drugs)
- ☐ according to the following instructions for (non-prescription drugs).

_____

_____

_____

Signature of parent or guardian:_____

Medication Record

Name of Child: _____Physician: _____

Name of Medication:_____

Date Commenced:_____Date Stopped:_____

Date	Time	Dosage	Comments	Staff Signature