

⇒ **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 ⇒	Time	Date	Dosage	Route
Expiration Date: ⇒	⇒	⇒	⇒	⇒
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	

Medication Log

(Completed by child care provider)

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date					
Actual time given	AM _____ PM _____				
Dosage/Amount					
Route					
Facility staff's Signature					
Time of first dose, administered by parent/guardian					

⇒

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date					
Actual time given	AM _____ PM _____				
Dosage/Amount					
Route					
Facility staff's Signature					
Time of first dose, administered by parent/guardian					

Please fill out marked (⇒) fields, sign, and bring to the Front Desk.