Permission to Administer Medication

Important: Fill out completely and legibly. We will not accept “as needed” instructions, please be very specific

Child’s Name:______________________________________ Date: ___________

Medication and Dosage: ____________________________ Time: ___________
____________________________ ___________
____________________________ ___________

Time medication last administered (important): ________________________________

Any possible side effects: ____

Parent/Guardian Signature:_____________________

***************************** STAFF USE ONLY ******************************

Medication administered by:___________________________ Time: ___________
____________________________ ___________
____________________________ ___________

Comments: ____

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Return This Portion to Parent/Guardian

Child’s Name: _________________________________ Date: ___________

Medication and Dosage: ____________________________

Medication administered by:___________________________ Time: ___________
____________________________ ___________
____________________________ ___________

Comments: ____