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

NOTE: Use one form for each medication dispensed. Completed form is to be filed in child's file.