Permission for Medication Administration at School and Child Care

The parent/guardian of		ask that scl	hool/child care staff give the
following medication	Child's Name	at	
Name o	of Medicine & Dosage	u	Time(s)
to my child, according to the Health	ı Care Provider's signed	instructions on	the lower part of this form.
Prescription medications must come medicine is to be given, dosage, rout name. Pharmacy name and phone nu	te, date medicine is to be	stopped, and lice	
Over the counter medication must be Provider authorization, and medicine r			match the signed Health Care
The school/child care agrees to adm prescriptive authority. The parent agnotification by staff. All medication(s) regulatory recommendations for safe r	grees to pick up expired left at the school will be	d or unused me	edication within one week of
By signing this document, I give po about the administration of this med			
Parent/Legal Guardian's Name	Parent/Legal Guardia	n Signature	Date
Work Phone	Alternate Phone		
******************************	**********	*****	*********
	alth Care Provider Aut	horization	
Child's Name:			Birthdate:
Medication:	Dosage:		Route:
To be given at the following times:	Start Date:		End Date:
Special Instructions:	I		
Purpose of Medication:			
Side Effects to be reported:			
Oissant are of the lith Osea Describes with Describe	and the second s	Dete	
Signature of Health Care Provider with Prescrip	puve Authority	Date	1
Print Name of Health Care Provider		Phone & Fax	Number
Signature of Child Care Health Consultant or S	School Nurse	Date	