Medication Permission Form

One form per child per medication.
This form should be completed by medical staff.

Date: _____

Child's Name: _____ D.O.B _____

Primary Health Care Provider: _____

Medication: _____

Dosage:_____Route: _____

To be given at the following times:_____

Purpose of medication:_____

Special Instructions:_____

Side effects that need to be reported: _____

Starting Date: _____ Ending Date: _____

Signature of Health Care Provider with Prescriptive Authority: _____

Phone Number: _____ License Number: _____

The parent/guardian of _____ ask that school/child care staff give the following medication _____to my child, according to the Health Care Provider's signed instructions above.

The program agrees to administer medication prescribed by a licensed health care provider.
It is the parent/guardian's responsibility to furnish the medication in the original container.
The parent/guardian agrees to pick up expired or unused medication within one week of notification by staff.

Prescription medications must be labeled with: child's name, name of medicine, time medicine is to be given, dosage, and date medicine is to be stopped, and licensed health care providers name. Pharmacy name and phone number must also be included on the label.

Over the counter medication must be labeled with child's name. Dosages on the package must match the signed health care provider authorization.

Parent/Legal guardian's name: _____

Parent/Legal Guardian's signature: _____Date:_____

Home Phone: _____ Work Phone: _____