PERMISSION TO ADMINISTER MEDICATION
(ONE FORM PER MEDICATION)

This form must be updated every 12 months or as needed. It is valid for one year from the date signed. Please retain a completed copy for your records.

PART I: to be completed by the parent or guardian

Child's Name: DOB:

I hereby give permission to a staff member who is trained in Medication Administration to administer to my child the medication prescribed below. I understand that this form must be filled out completely, that I must provide the medication, and that the medication is to be brought in its original, pharmacy labeled container that states the child's name, the pharmacy's phone number, the health care provider, the name of the medication, and dosing information. I agree to replace the medication if it is about to expire and understand that if this form is not returned or is not current, the prescribed medication will **not** be administered to my child.

Signature: Date:

PART II: to be completed by the health care provider with prescriptive authority

Child's Name: DOB:

Medication:

Purpose of medication:

Possible side effects:

Dosage: Route:

Time to be given:

Start date: End date:

Special Instructions:

Signature: Date:

Office Stamp