INDIVIDUAL PERMISSION FOR MEDICATION OR HEALTH CARE PROCEDURE

Name of Child:

Child's condition for administering medication:

- ☐ Cold
- ☐ Sore Throat
- ☐ Teething
- ☐ Ear Infection
- ☐ Rash
- ☐ Injury
- ☐ Other:

Name of medication/procedure:

- ☐ Prescription:
- ☐ Non-prescription:
- ☐ Doctor's approval required:

Amount to be administered: _____

Times to be administered: _____

Dates to be administered: _____ to _____

Refrigeration necessary: ☐ Yes ☐ No

Special instructions:

Possible adverse reactions:

I authorize the administration of medication to my child.

Signature of Parent/Guardian: Date:

FOR CENTER USE:

- ☐ Is all of the above information complete?
- ☐ Has the medication been made inaccessible to children?
- ☐ Is the medication in the original container with the prescription label on it?
- ☐ Is the child's name on the container?
- ☐ Is the date of the prescription current?
- ☐ Is the name of the drug/procedure, dose, and schedule on the label the same instructions given by the parent?

Date(s) Administered:	Time(s) Administered:	Adverse Reactions Observed:	Staff Initials: