Medication Permission Form

Child's Full Name_____ Date _____

Name of Medication _____

_____ Prescription _____ Non-Prescription

Time of Last dose given _____

Condition for administering Medicine_____

Amount to be administered _____

Date(s) to be administered _____

Time(s) to be administered _____

Possible adverse reactions _____

Parent's signature _____

Staff member's signature _____

Staff member(s) authorized to administer medication _____

Date administered	Time administered	Adverse reaction observed	Staff member's initials