## Permission for Medication Administration at School and Child Care

The parent/guardian of		ask tha	at school/child care staff give the
falls, winer madination	Child's Name	at	
following medication	Name of Medicine & Dosa		Time(s)
to my child, according to the		-	ns on the lower part of this form.
Prescription medications must medicine is to be given, dosagname. Pharmacy name and pl	ge, route, date medici	ne is to be stopped, a	's name, name of medicine, time nd licensed Health Care Provider's bel.
Over the counter medication reprovider authorization, and me	nust be labeled with o dicine must be packaç	:hild's name. Dosage r ged in original containe	must match the signed Health Care r.
prescriptive authority. The pa	arent agrees to pick ation(s) left at the sch	up expired or unuse nool will be discarded	icensed Health Care Provider with d medication within one week o according to the most current state
By signing this document, I about the administration of t	give permission for this medication with	my child's Health Ca the school staff deleg	are Provider to share information pated to administer medication.
Parent/Legal Guardian's Name	Parent/L	egal Guardian Signature	Date
Work Phone	Alternate Phone		
**************************	********************	******	**********
		ovider Authorization	n
Child's Name:	moditi odro : :		Birthdate:
Medication:		Dosage:	Route:
To be given at the following times	3:	Start Date:	End Date:
Special Instructions:			
Purpose of Medication:			
Side Effects to be reported:			
Signature of Health Care Provider w	ith Prescriptive Authority	Date	
Print Name of Health Care Provider		Phone	e & Fax Number
Signature of Child Care Health Cons	sultant or School Nurse	Date	