

PERMISSION TO ADMINISTER MEDICATION

DATE: _____

I hereby give my permission to the staff of _____ to administer:

Name of Medication

Prescription Number

to my child _____ according to the Doctor's orders and instructions.

(These will be on the vial or bottle for prescription drugs and on the "Request for Administration of Non-Prescription Medication at Child Care Centre" form for non-prescription drugs).

Signature of Parent or Guardian

MEDICATION RECORD

NAME OF CHILD: _____ PHYSICIAN: _____

NAME OF MEDICATION: _____

DATE COMMENCED: ____/____/____ DATE STOPPED: ____/____/____

DATE	TIME	DOSAGE	COMMENTS	STAFF SIGNATURE

NOTE: One form for each prescription or refill.
Completed form filed in child's file.

H516-92/01

**REQUEST FOR ADMINISTRATION OF
NON-PRESCRIPTION MEDICATION AT CHILD CARE FACILITY**

A. TO BE COMPLETED BY PARENT OR GUARDIAN:

NAME OF CHILD: _____ BIRTHDATE: ____/____/____

NAME OR GUARDIAN: _____

PHONE: HOME: _____ BUSINESS: _____

PHYSICIAN: _____ PHONE: _____

B. TO BE COMPLETED BY PHYSICIAN

CONDITION WHICH MAKES MEDICATION NECESSARY:

NAME OF MEDICATION: _____

DOSAGE: Pills _____ Drops _____ Tsp. _____ Ounces _____ Mls. _____

TIME: A.M. _____ P.M. _____ DATE TO START: ____/____/____

TO BE GIVEN WITH: _____ DATE TO GIVE LAST DOSE: ____/____/____
(Water, Milk, Juice)

ADDITIONAL COMMENTS: (Possible Reactions, Consequences of Missing Medication, etc.)

DATE: ____/____/____

SIGNED: _____

PHONE NO: _____