

PERMISSION FOR MEDICATION

(This form must be completed and signed for all over the counter and prescription medications)

Name of Child _____

Primary Health Care Provider _____

Phone Number _____

Medication _____ Dosage _____ Route _____

Purpose of Medication _____

Time of day medication is to be given _____

Possible side effects _____

Anticipated number of days it needs to be given at child care facility _____

Date _____

Signature of Person with Prescriptive
Authority

Parent/Guardian

I hereby give my permission for _____ to take the
above prescription or over-the-counter medication at the child care facility
as ordered.

I understand that it is my responsibility to furnish this medication.

Date _____

Signature of Parent or Guardian

**Note: The prescription medication is to be brought to the child care facility in its
original pharmacy container appropriately labeled by the pharmacy or person
with prescriptive authority along with a copy of this medication authorization
order.**