

INDIVIDUAL PERMISSION FOR MEDICATION OR HEALTH CARE PROCEDURE

Name of Child: _____

Child's condition for administering medication:

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Cold | <input type="checkbox"/> Sore Throat |
| <input type="checkbox"/> Teething | <input type="checkbox"/> Ear Infection |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Injury |
| <input type="checkbox"/> 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: