

Permission to Administer Medication

Child's Name _____

Start prescription date: _____ End prescription date: _____

Doctor's Name: _____

Reason medication was prescribed: _____

Name of prescribed medication: _____

TIME(S) MEDICATION IS TO BE GIVEN BY CAREGIVER:

TIMES MEDICATION IS TO BE GIVEN BY PARENTS:

AMOUNT TO BE GIVEN AT EACH DOSE: _____

MEDICATION RELEASE: I, _____ give my permission for my caregiver, _____ to administer the above prescription medication (according to the above guidelines) to my child, (enter child's name here:) _____.

I understand that my caregiver will not be held responsible for allergic reactions or other complications resulting from the administration of the above medication, given according to the directions.

Parent Signature: _____ Date: _____

ADMINISTRATION RECORD:

Date: _____ Time: _____ Amount given _____ Initials: _____

Comments: _____

Date: _____ Time: _____ Amount given: _____ Initials: _____

Comments: _____

Date: _____ Time: _____ Amount given: _____ Initials: _____

Comments: _____

Date: _____ Time: _____ Amount given _____ Initials: _____

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