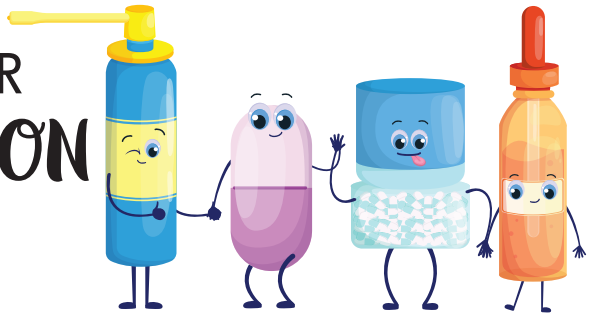
AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION



CHILD INFO

Name	Age	Dob

MEDICATION INFO

Medication's name	
Reason for medication	
Dose	
Time / Frequency	
Route	Oral ☐ Topical ☐ Inhaled ☐ Other ☐
Start date	Finish date
Additional instructions	
Possible side effects	

FOR PRESCRIPTION MEDICATION

Prescribing Physician	Phone

☐ I _____ , authorize _____ personnel to administer the medication named above to my child in the manner as stated. I release any liability in relation to the asministration of this medication. I also acknowledge that I, the parent/guardian, have given the first dose of this medication without any allergic or unexpected reactions.

Parent/Guardian Signature _____ Date _____

RETURN OR DISPOSAL OF MEDICATION

Return Date	Parent / Guardian signature
Disposal Date	Staff signature
Witness to disposal	

All prescription medication must be in the original container and clearly labeled with the child's name.