

Permission VALID: From ___/___/___ To ___/___/___

MEDICATION ADMINISTRATION PERMISSION & RECORD

Information about the child and the medicine
(Completed by parent/guardian)

Child's Name			Child's Date of Birth	
Medicine	Time	Date	Dosage	Route
Expiration Date:				
Special Instruction:				
Possible Reactions:				
Prescribing provider:			Phone:	
Pharmacy:			Phone:	
I give authorization to give medicine and to call the health care provider if needed. Parent/Guardian signature				Date
RETURNED to Parent/Guardian	Date	Parent/Guardian signature	Child Care Staff signature	
DISPOSED of Medicine	Date	Child Care Staff signature	Witness signature	

Medication Log
(Completed by child care provider)

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date					
Actual time given	AM ____ PM ____	AM ____ PM ____	AM ____ PM ____	AM ____ PM ____	AM ____ PM ____
Dosage/Amount					
Route					
Facility staff's Signature					

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date					
Actual time given	AM ____ PM ____	AM ____ PM ____	AM ____ PM ____	AM ____ PM ____	AM ____ PM ____
Dosage/Amount					
Route					
Facility staff's Signature					