Medication Permission Form

Child's Name____

I request that the following over the counter medication be administered to my child. Note to parents: if a written dosage is not listed on the medication label, a written and signed permission from the child's physician with a correct dosage amount must accompany this permission form.

Name of medication:____

Strength of medication: _____________________________ Expiration Date: ________________

Reason for Medication:____

Possible side effects:____

Instructions for use:____

Age appropriate dosage: ____

Dosage to be given:________________________ Time to be administered:_________________________

Dates medication should be administered:____

Storage of Medication: ____

Physician's name:____

Address:____ Phone:_________________________

I request that the above medication be given to my child as described. I, release The "Lana's Dwarfs" personnel from any liability in relation to the administration of this medication at the center.

Parent Signature____ Date_____________________

Program Personnel: completely fill out the following information upon dispensing medication.

Date:___________________________ Date:____________________________

Time:___________________________ Time:____________________________

Dosage given:___________________ Dosage given:_____________________

Printed name:___________________ Printed name:_____________________

Signature:______________________ Signature:________________________

Date:___________________________ Date:____________________________

Time:___________________________ Time:____________________________

Dosage given:___________________ Dosage given:_____________________

Printed name:___________________ Printed name:_____________________

Signature:______________________ Signature:________________________

Date:___________________________ Date:____________________________

Time:___________________________ Time:____________________________

Dosage given:___________________ Dosage given:_____________________

Printed name:___________________ Printed name:_____________________

Signature:______________________ Signature:________________________

Attach another form when this form becomes full. Forms must be stapled together.

Medicine returned to parents: yes no Date Returned:________________________

If no, why was medication not returned? ____

THIS FORM MUST BE COMPLETELY FILLED OUT IN ORDER FOR MEDICATION TO BE ADMINISTERED.
ALL MEDICATION MUST BE IN THE ORIGINAL PACKAGING.
Place this form in child's file when medication is complete.