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 Expiration Date:	Time	Date	Dosage	Route
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					