## II.5. MEDICATION PERMISSION #1

Child's Name________________ Child's Address____________________

I have prescribed the following medication for this child and request that dosage falling during Center hours be administered by Center personnel. Note: Authorization is needed for non-prescription medications, also.

MEDICATION______________________________________________

Condition for which prescribed______________________________

Possible Side Effects_______________________________________

Instructions for use_______________ Dosage_____________ Time______

Frequency________________________ How Long?____________________
(No. of Days)

Date_____________________ SIGNATURE_____________________________
(Physician)

Address:_____________________________

Telephone No.:_______________________

Pharmacy_______________ Phone_______________ Rx No.__________

I request the above medication be given to my child as prescribed

Date____________________ SIGNATURE OF PARENT or GUARDIAN____________________

CENTER STAFF: Fill in date, time and initials whenever dispensing medicine.

| MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY |
| --- | --- | --- | --- | --- |
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DISPOSITION OF MEDICINE: Returned to Parents:__________ Date______

Please place this form in the child's folder when medication is complete.

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