***MEDICATION PERMISSION FORM***

This form must be filled out by a parent/guardian before any medications can be administered to the child by a staff member. A new form must be submitted every Monday. Medication shall be dispensed out of its original container which must be labeled with the child’s name and the pharmacy label must accompany the medication.

Child’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_

Name of Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescription Number : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Times Medication is to be given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates to be given *: From -* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *To -* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **DATE** | **TIME** | **AMOUNT** | **GIVEN BY** | **REACTIONS** |
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Describe action taken if any noticeable adverse reactions occurred:

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