

## INDIVIDUAL PERMISSION FOR MEDICATION OR HEALTH CARE PROCEDURE

Name of Child: \_\_\_\_\_

Child's condition for administering medication:

- |                                       |  |
|---------------------------------------|--|
| <input type="checkbox"/> Cold         | <input type="checkbox"/> Sore Throat   |
| <input type="checkbox"/> Teething     | <input type="checkbox"/> Ear Infection |
| <input type="checkbox"/> Rash         | <input type="checkbox"/> Injury        |
| <input type="checkbox"/> Other: _____ |  |

Name of medication/procedure: \_\_\_\_\_

- Prescription:
- Non-prescription:
- Doctor's approval required:

Amount to be administered: \_\_\_\_\_

Times to be administered: \_\_\_\_\_

Dates to be administered \_\_\_\_\_ to \_\_\_\_\_

Refrigeration necessary:     Yes     No

Special instructions: \_\_\_\_\_

Possible adverse reactions: \_\_\_\_\_

***I authorize the administration of medication to my child.***

Signature of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

### FOR CENTER USE:

- Is all of the above information complete?
- Has the medication been made inaccessible to children?
- Is the medication in the original container with the prescription label on it?
- Is the child's name on the container?
- Is the date of the prescription current?
- Is the name of the drug/procedure, dose, and schedule on the label the same instructions given by the parent?

Date(s) Administered:	Time(s) Administered:	Adverse Reactions Observed:	Staff Initials: