



# Santa Fe Centers

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## PERMISSION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION

*(Please use one form per medication.)*

The following information is to be completed by the child's health care provider:

Child's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Weight: \_\_\_\_\_

Medication: \_\_\_\_\_ Allergies: \_\_\_\_\_  
*Include food and/or medication allergies*

Dosage: \_\_\_\_\_ Route: \_\_\_\_\_

Time of day medication is to be given: \_\_\_\_\_

Purpose of medication: \_\_\_\_\_

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

Possible side effects: \_\_\_\_\_

Start date: \_\_\_\_\_ End date \_\_\_\_\_

\_\_\_\_\_  
*Signature of Health Care Provider                      Phone number                      Date*

The following is to be completed by the parent or guardian:

I hereby give permission for my child, \_\_\_\_\_, to receive the above medication, according to the listed directions and cautions, from the Child Care Director, or the Child Care Director designee. I confirm that I have given at least one dose of the medication without any evidence of side effects or adverse reactions. I understand that it is my responsibility to provide the medication in its original container and labeled with my child's full name. I am also to supply the appropriate measuring device needed to give the accurate dose of the medicine. I authorize the Director or Director Designee to contact the pharmacist or health care provider for more information about this drug, if necessary. I also authorize the Director or the Director's Designee to contact the health care provider regarding my child's health, if necessary.

I usually do the following to make giving medication to my child easier: \_\_\_\_\_  
\_\_\_\_\_

Amount of medication brought to Child Care: \_\_\_\_\_

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

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

*Signature of Parent or Guardian*

Date & amount of medication returned to Parent: \_\_\_\_\_

\_\_\_\_\_  
*Signature of Director/Director Designee*

\_\_\_\_\_  
*Signature of Parent/Guardian*