

## 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:		_
Dosage:		food and/or medication allergies	
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	
supply the appropriate measuring device needed Designee to contact the pharmacist or health car Director or the Director's Designee to contact the I usually do the following to make giving medicar	re provider for more informati health care provider regarding tion to my child easier:	on about this drug, if necessary my child's health, if necessary.	
Amount of medication brought to Child Care:			
Expiration Date:			
Date:			
	Signature of Parent or Gu	ardian	
Date & amount of medication returned to Parent:			
Signature of Director/Director Designee	Sionatur	re of Parent/Guardian	

Source: Medication Administration in Child Care, Healthy Child Care New Jersey