

Child's Name _____

PARENT COMPLETE THIS SECTION

STAFF COMPLETE THIS SECTION

I give permission to administer medication to my child as stated below:

Date	Parent's Signature	Name of Medication/ Any side effects to watch for	To Be Given		Amount Each Dose/ by Route, e.g., Mouth, Nose, Ear	Refrigerate?	Safety Check*	Time Given	Staff Name	Date Given	Reaction/Notes
			Date	Time							

- *Safety Check:
1. Child-resistant container
 2. Original prescription or manufacturer's label with the name and strength of the medication and physician's directions for use (phone or written)
 3. Name of child on container is correct for both first and last names
 4. Current date on prescription/expiration label covers period when medication is to be given
 5. Name and phone number of licensed health professional who ordered medication on container or on file
 6. Instructions are clear for dose, route, and time to give medication