PERMISSION TO ADMINISTER MEDICATION

All medication must be in the original container with the child's name, name of the physician, medication name, and medication directions written on the label.

Medication which has expired or is no longer being administered shall be returned to the parent or guardian.

Child's Name:_____

Medication Name:_____ Expiration Date:_____

Physician's Name:_____

Amount to be administered:_____

Time(s) to be administered:_____

Date(s) to be administered: _____

I give permission to dispense the medication(s) listed above in accordance with the written directions on the prescription label.

Signature of Parent/Guardian_____ Date:_____

Record of Medication Administered

Medication Name_____

Date & Time	Amount	Employee
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____