Medication Administration Form

Authorization to Give Medicine - TO BE COMPLETED BY PARENT

CHILD'S INFORMATION

"Let Them Be Little Childcare" - Desiree Valdez Today's Date ___/___/____

Name of Facility

_____ Today's Date ___/___/____

Name of Child (First and Last)

Name of Medicine_____

Reason Medicine Is Needed During Childcare Hours_____

Dose_____Route_____

Time To Give Medicine_____

Additional Instructions_____

Date To Start Medication_____/_____/_____ Stop Date____/____/_____

Known Side Effects Of Medicine_____

Plan Of Management Of Side Effects_____

Childs Allergies_____

PRESCRIBER'S INFORMATION

_____

Prescribing Health Professional's Name

_____

Phone Number

PERMISSION TO GIVE MEDICINE

I hereby give permission for **"Let Them Be Little" Childcare - Desiree Valdez** *to administer medicine as prescribed above. I also give permission for the caregiver to contact the prescribing health professional about the administration of the medicine. I have administered at least two doses of medicine to my child without adverse effects.*

_____

Parent or Guardian Name (Print)

_____

Parent or Guardian Signature

_____

Address

_____

Home Phone Number **Work Phone Number** **Cell Phone Number**