

PARKSIDE
PLAYSCHOOL

Medicine Permission Slip

Child's Name _____ Today's Date _____

Name of Medication _____

Dosage _____

What is medication being given for? _____

Type (pill, liquid, ointment, etc.) _____

Route (mouth, eye, ear, nose, skin) _____

Date(s) to be Administered _____

Time(s) to be Administered _____

Parent's Signature _____