INDIVIDUAL PERMISSION FOR MEDICATION/HEALTH CARE PROCEDURE (NOT FEVER REDUCER OR PAIN RELIEVER)

Student's Name: _____

Condition for administering medication:
□ asthma □ cold □ teething □ injury □ ear infection □ rash
□ other _____

Name of Medication/Procedure: _____
□ Prescription □ Non-Prescription □ Doctor's Approval Required

Amount to be administered: _____
Time to be administered: _____
Dates to be administered: From _____ To _____
Is refrigeration necessary? □ Yes □ No

Special Instructions:
_____
_____

Possible adverse reactions:
_____
_____

I authorize the administration of medication and/or procedure to my child.

_____ _____
Parent's Signature Date

Date(s) Administered	Time(s) Administered	Adverse Reactions Observed	Staff Initials

Date(s) Administered	Time(s) Administered	Adverse Reactions Observed	Staff Initials

- Is all of the above information complete?
- Is the medication in the original container with the prescription label on it?
- Is the date of the prescription current?
- Is the child's name on the container?
- Is the name of the drug/procedure, dose, and schedule on the label the same as the instructions given by the parent?
- Has the medication been placed out of reach of children?