



Permission for Medication
Teaching Tree Early Childhood Learning Center

Name of Child: _____ Age: _____

Classroom: _____

Teacher (s): _____

Primary Health Care Provider : _____

Medication: _____ Dosage: _____ Route: _____

Purpose of medication: _____

Time of day Medicine is to be given: _____

Possible Side Effects: _____

Anticipated number of days medication needs to be given while child is in care: _____

Start date for medication to be given: _____ End date for medication to be given: _____

Date: _____

Signature of Person with Prescriptive Authority

Parent/Guardian:

I hereby give my permission for _____ to take the above prescription or over-the-counter medication at Teaching Tree Early Childhood Learning Center as ordered.

I understand that it is my responsibility to furnish this medication.

Date: _____

Signature of Parent/Guardian

*Note: All medication is to brought to TTELC in the original pharmacy container appropriately labeled by the pharmacy or person with prescriptive authority along with the medication authorization order.