

Child Care Facility Name _____

DCD - A/N
Form 12A-r

Permission to Administer Medication

I give permission for my child to be given the following medication:

Child's Name: _____

Name of Medication: _____ Expiration Date: _____

Dosage: _____ Refrigerate

Dates to be Given: _____

Times to be Given: (_____) (_____) (_____)

Special Instructions: _____

Possible Reactions: _____

Parent's Signature: _____ Date: _____

	Monday	Tuesday	Wednesday	Thursday	Friday
Medication:					
Dosage:					
Date:					
Times:					
Facility Staff's Signature:					

*** RETURN MEDICATION TO PARENT UPON COMPLETION ***

Revised Sample 9/99

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