

# Permission to Give Medication in Child Care

*(Please use one form per medication)*

*The Following information is to be completed by the child's health care provider:*

Child's name: \_\_\_\_\_ Birthdate \_\_\_\_\_ Wt: \_\_\_\_\_

Medication: \_\_\_\_\_ Allergies \_\_\_\_\_  
Include food and/or medication allergies

Dosage: \_\_\_\_\_  
Route \_\_\_\_\_

Time of day medication is to be given \_\_\_\_\_

Purpose of medication \_\_\_\_\_

Special Instruction: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Start date: \_\_\_\_\_ End Date: \_\_\_\_\_

\_\_\_\_\_  
*Signature of Health Care Provider*      *Phone*      *Date*

*The following is to be completed by the parent or guardian:*

I hereby give permission for my child, \_\_\_\_\_, to receive the above medication, according to the listed direction and cautions, from the Child Care Director or the Child Care Director designee. I confirm that I have given at least one does of the medication without any evidence of side effects or adverse reaction. I understand that it is my responsibility to provide the medication in its original container and labeled with my child's full name. I am also to supply the appropriate measuring device needed to give the accurate does of the medicine.

**I authorize the Director or Director Designee to contact the pharmacist or health care provider for more information about this drug, if necessary. I also authorize the Director or the Director's Designee to contact the health care provider regarding my child's health, if necessary.**

I usually do the following to make giving medication to my child easier \_\_\_\_\_

Amount of medication brought to Child Care \_\_\_\_\_

Date \_\_\_\_\_

*Signature of Parent or Guardian*

Date & Amount of Medication returned to Parent: \_\_\_\_\_

\_\_\_\_\_