Class:_____ Permission VALID: From ____/____/____ To ____/____/____
(must be renewed every 6 months)

MEDICATION ADMINISTRATION PERMISSION & RECORD

(Completed by parent/guardian)

Information about the child and the medicine (Completed by parent/guardian)			
Child's Last Name:	First Name:		DOB: ____/____/____
Medicine:	Dosage:	Route:	Exp. Date: ____/____/____
	Date(s):	Time:	
Special Instructions:			
Possible reactions:			
Prescribing Provider:		Phone:	
Pharmacy:		Phone:	
I give authorization to give medicine and to call the health care provider if needed. Parent/Guardian Signature:			Date: ____/____/____

MEDICATION LOG

(Completed by staff)

CLASSROOM DELIVERY	Date: ____/____/____	Method of Delivery:	Staff/Parent Signature:
RETURNED To Parent/Guardian:	Date: ____/____/____	Parent/Guardian Signature:	Staff Signature:
DISPOSED of Medicine:	Date: ____/____/____	Staff Signature:	Witness Signature:
Medicine:			
Dosage:			
Route:			
	Date:___/___/___	Time:	Staff Signature:
	Date:___/___/___	Time:	Staff Signature:
	Date:___/___/___	Time:	Staff Signature:
	Date:___/___/___	Time:	Staff Signature:
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	Date:___/___/___	Time:	Staff Signature:
	Date:___/___/___	Time:	Staff Signature:

Medicine:			
Dosage:			
Route:			
	Date:_____/_____/_____	Time:	Staff Signature:
	Date:___/___/___	Time:	Staff Signature:
	Date:___/___/___	Time:	Staff Signature:
	Date:___/___/___	Time:	Staff Signature:
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