

INDIVIDUAL PERMISSION FOR MEDICATION OR HEALTH CARE PROCEDURE

Name of Child: _____

Child's condition for administering medication:

Cold Sore Throat Rash Ear infection Teething
 Injury Other _____

Name of Medication/Procedure _____

Prescription Non-Prescription Doctor's approval required

Amount to be administered _____

Time(s) to be administered _____

Dates to be administered From _____ To _____

Refrigeration necessary Yes No

Special Instructions

Possible adverse reactions _____

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

I authorize My Little University to administer medication to my child:

_____ Date: _____

Parent's Signature

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

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