

Individual Medication Permission Form and Medication Record

Date			
Child's name			
Name of Medication			
☐ Prescription	☐ Non-Prescription☐ Doctor's approval	☐ Written ☐ Phone call	Date
Condition for administering med	licine		
Amount to be administered			
Time(s) medication is to be admi	inistered		
Start date	End date		
Refrigeration necessary?	☐ yes	☐ no	
Possible adverse reactions			
Parent/Guardian signature			
Staff member(s) authorized to a	dminister medication		
Date and time administered	Adverse reactions observed		Staff member's initials
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