Medication Permission Form

Name of Medication: _____ Expiration Date: _____

Physician: _____

Date to be Given: _____ Times to be Given: _____

Route of Administration (oral, topical, etc.):

_____

Illness or Condition Being Treated:

_____

Possible side effects or Drug Interactions:

_____

I hereby give authorization for the staff to administer the above medication according to the above instruction. I recognize that the staff will not be held for any illness or injury resulting from the administration of this medication and will not be held responsible for reimbursement of medical expenses resulting from such actions.

_____ _____

Signature of Parent or Guardian Date

Verbal Authorization: Date & Time: _____ Staff Signatures _____

Parent's Signature: _____

MEDICATION RECORD

Date	Time	Dosage	Administered By	Supervised By	Error in Administration	Reactions

_____

SIGNATURE OF PARENT DATE