INDIVIDUAL PERMISSION FOR MEDICATION OR HEALTH CARE PROCEDURE			
Name of Child:			
Child's condition for adminis Cold Teething Rash Other:	tering medication: Sore Throat Ear Infection Injury	Name of medication/procedure: Prescription: Non-prescription: Doctor's approval required:	
Amount to be administered: Times to be administered: Dates to be administered: Refrigeration necessary: Yes No		Special instructions: Possible adverse reactions:	
I authorize the administration of medication to my child. Signature of Parent/Guardian: Date:			
FOR CENTER USE: Is all of the above information complete? Has the medication been made inaccessible to children? Is the medication in the 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 drug/procedure, dose, and schedule on the label the same instructions given by the parent?			
Date(s) Administered:	Time(s) Administered:	Adverse Reactions Observed:	Staff Initials: