

PERMISSION TO ADMINISTER PRESCRIPTION MEDICATION

Child's Full Name _____

Date _____

Name of medication _____

Dosage _____

Time(s) of Dosage _____

Any special instructions (take with food, on an "as needed" basis, etc.):

Start Date of Prescription _____

End Date of Prescription _____

Possible side effects _____

Rx Number _____

Name of Pharmacy _____

Pharmacy Address _____

Pharmacy Phone _____

Name/Phone of prescribing Physician _____

I release _____ from any liability from administering
(name of provider)

this medication.



(parent signature)

(date)

*All Prescription Medication must be in the original container clearly labeled with the child's name and dispensing instructions.