

PERMISSION TO ADMINISTER MEDICATION

I hereby give my permission to : _____
(NAME OF CHILD CARE PROVIDER)

to administer medication to: _____
(NAME OF CHILD)

NAME OF MEDICINE: _____

REASON FOR TAKING MEDICINE: _____

AMOUNT/DOSAGE: _____

MEDICINE TO BE GIVEN FROM: _____ TO _____
(DATE) (DATE)

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

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