PERMISSION TO ADMINISTER PRESCRIPTION MEDICATION

Child's Full Name ____

Date ______________________

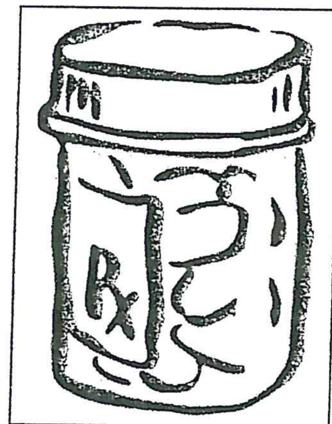
Name of medication ____

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.

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