

**Medication Permission Form**

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| **CHILD’S INFORMATION** |
| NAME OF CHILD | DATE OF BIRTH | TODAY’S DATE |
| NAME OF MEDICINE | DOSE |
| TIME(S) TO GIVE MEDICINE |
| DATE TO START MEDICINE | DATE TO STOP MEDICINE |
| KNOWN SIDE EFFECTS TO MEDICINE |
| ADDITIONAL INSTRUCTIONS |
| HOW IS THIS MEDICINE GIVEN? (CIRLCE ONE) BY MOUTH IN THE EAR  IN THE EYE  NEBULIZER ON THE SKIN OTHER  | CHILD ALLERGIES |
| **PRESCRIBER’S INFORMATION** |
| PRESCRIBING HEALTH PROFESSIONAL’S NAME |
| **PERMISSION TO GIVE MEDICINE** |
| I hereby give permission for the licensee to give the medication as prescribed above. |
| PARENT OR GUARDIAN NAME (PRINT) |
| PARENT OR GUARDIAN SIGNATURE | DATE |
| ADDRESS |
| HOME PHONE NUMBER**(     )     -** | CELL PHONE NUMBER**(     )     -** | ALTERNATIVE PHONE NUMBER**(     )     -** |