

**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  **(     )     -** | |