



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? (CIRCLE ONE) <input type="checkbox"/> BY MOUTH <input type="checkbox"/> IN THE EAR <input type="checkbox"/> IN THE EYE <input type="checkbox"/> NEBULIZER <input type="checkbox"/> ON THE SKIN <input type="checkbox"/> 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. I have given at least one dose of medicine to my child without adverse effects.		
PARENT OR GUARDIAN NAME (PRINT)		
PARENT OR GUARDIAN SIGNATURE	DATE	
ADDRESS		
HOME PHONE NUMBER () -	CELL PHONE NUMBER () -	ALTERNATIVE PHONE NUMBER () -



NAME OF CHILD:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Date							
Medicine							
Time Given	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Dosage/Amount							
Licensee Signature							
Notes/Concerns							

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Date							
Medicine							
Time Given	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Dosage/Amount							
Licensee Signature							
Notes/Concerns							

Signatures:

Medication returned to parent/guardian

Date:

Parent/Guardian signature:

Licensee Signature: