

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.