

### Authorization for Medication

No medication shall be given by the facility staff without the signed permission of parent or guardian.

Child's Name: \_\_\_\_\_ Week of: \_\_\_\_\_

Date	Time	Amount	Staff Initials

Name of Medication: \_\_\_\_\_

Amount to be given: \_\_\_\_\_

Time to be given: \_\_\_\_\_

Directions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*My signature indicates authorization for facility staff to administer medication to my child according to the directions provided above.*

\_\_\_\_\_

Parent/Guardian Signature

\_\_\_\_\_

Date

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Parent/Guardian Signature

\_\_\_\_\_

Date

