Authorization to Administer Medication

Child's Name:_____ Birth Date:_____

Name of Medication: _____

Dosage Amount:_____ Dosage Schedule:_____

Date to Start:_____ Date to finish:_____

Purpose of medication/Reason for giving:_____

Special Instructions/Storage of Medication:_____

_____

_____

I give *New Dream Family Center* permission to administer medication to my child

Parent signature:_____ Date:_____

Date/Time	Dosage Amount	Staff Signature