Parent/Guardian Permission To Administer
PRESCRIPTION
Medication

BETHANY CHILD CARE CENTRE

Please complete a separate form for each medication required. Each medication ***must*** be in the original pharmacy labelled container prescribed for the child identified below.

Child's Name ___________________________________ Birthdate ______________________
y/m/d

Name of Medication ____

Reason for Medication ____

Dosage ______________________ Route of Administration _____________________________

Time/times medication to be given ____

Physician's Name: _________________________________ Phone ______________________

I hereby give my permission for the staff to administer the above named medication to my child according to the physician's order and instructions. I agree to complete a new permission form if there are any changes to the medication or instructions.

Parent/Guardian Name: _____________________________ Phone _______________________
(please print)

Date ________________ Parent/Guardian Signature ___________________________________
y/m/d

………………………………………………………………………………………………..

(To be completed when unused medication/medication container returned to parent/guardian)

☐ Medication/container received from caregiver.

Date ________________ Parent/Guardian Signature ___________________________________
y/m/d

NOTE TO CAREGIVER: ***Each time the medication is given it must be recorded on the Medication Record on reverse.***