Permission to Administer Medication Form

DATE: ___________________________________

I hereby give my permission to the staff at EASI JK Program to administer:

____ ___________________________

(Name of Medication) (Prescription Number)

to my child _________________________________ according to the doctor's orders and

(Full Name of Child)

instructions. These instructions will be on the vial or bottle for prescription drugs and on the **Request for Administration of Non-Prescription Medication Form** for non-prescription drugs.

Full Name of Parent/Guardian: ____

Signature of Parent/Guardian: _________________________________

MEDICATION RECORD

NAME OF CHILD: _______________________________ PHYSICIAN _________________________

NAME OF MEDICATION: ____

DATE COMMENCED: _____/_____/______ DATE STOPPED: _____/_____/_______

DATE	TIME	DOSAGE	COMMENTS	STAFF SIGNATURE

NOTE: One form for each prescription or refill.
Completed form filed in child's file.

Request for Administration of Non-Prescription Medication Form

A. TO BE COMPLETED BY PARENT OR GUARDIAN:

NAME OF CHILD: ________________________________ BIRTHDATE: _____/_____/______

NAME OR GUARDIAN: ____

PHONE: (CELL) _____-_____-______ (HOME) _____-_____-______ (WORK) _____-_____-_____

PHYSICIAN NAME: ____________________________________ PHONE: _____-_____-______

B. TO BE COMPLETED BY PHYSICIAN:

CONDITION WHICH MAKES MEDICATION NECESSARY:

____

____

NAME OF MEDICATION: ____

DOSAGE: Pills _________ Drops _________ Tsp. _________ Ounces _________ Mls. _________

TIME: A.M. ________ P.M. ________ DATE TO START: _____/_____/______

TO BE GIVEN WITH: ____________ (Water, Milk, Juice) DATE TO GIVE LAST DOSE: ____/____/______

ADDITIONAL COMMENTS : (Possible Reactions, Consequences of Missing Medication, etc.)

____

____

DATE: _____/_____/______

SIGNATURE OF PHYSICIAN: _________________________________

PHONE NO.: _____-_____-______