# Medication Administration Packet

Authorization to Give Medicine
**PAGE 1—TO BE COMPLETED BY PARENT**

## CHILD'S INFORMATION

_____ ____/____/____
Name of Facility/School Today's Date

_____ ____/____/____
Name of Child (First and Last) Date of Birth

Name of Medicine _____

Reason medicine is needed during school hours _____

Dose _____ Route _____

Time to give medicine _____

Additional instructions _____

Date to start medicine _____/_____/_____ Stop date _____/_____/_____

Known side effects of medicine _____

Plan of management of side effects _____

Child allergies _____

## PRESCRIBER'S INFORMATION

_____
Prescribing Health Professional's Name

_____
Phone Number

## PERMISSION TO GIVE MEDICINE

I hereby give permission for the facility/school to administer medicine as prescribed above. **I also give permission for the caregiver/teacher to contact the prescribing health professional about the administration of this medicine. I have administered at least one dose of medicine to my child without adverse effects.**

_____
Parent or Guardian Name (Print)

_____
Parent or Guardian Signature

_____
Address

_____
Home Phone Number Work Phone Number Cell Phone Number

Adapted with permission from the NC Division of Child Development to the Department of Maternal and Child Health at the University of North Carolina at Chapel Hill, Connecticut Department of Public Health, and Healthy Child Care Pennsylvania.