AUTHORIZATION TO ADMINISTER MEDICATION

OUR NEIGHBORHOOD CHILD DEVELOPMENT CENTER

Start Date:

End Date:

Our Neighborhood Child Development Center

Our Neighborhood Child Development Center has by permission to administer the following medication:

Name of Medication: _____ Dosage: _____

Times or reason to be given: _____

This authorization is effective until : _____

Parent or Guardian's Signature: _____

Physicians Signature: _____

Note: We can only give medication in accordance with the manufacturer's instructions unless otherwise directed by a physician.

In accordance with our policies and procedures physicians authorization is required for all medications.

	DATE	TIME	DOSE	MEDICATION	Adverse Reaction/Errors	GIVEN BY
DAY 1						
DAY 2						
DAY 3						
DAY 4						

	DATE	**TIME**	**DOSE**	**MEDICATION**	**Adverse Reaction/Errors**	**GIVEN BY**
DAY 5						
DAY 6						
DAY 7						
DAY 8						
DAY 9						
DAY 10						

Parents Notified to Pick Up Medication Date	
Picked Up or Dumped (14 days from expiration of this authorization)	