MEDICATION PERMISSION FORM

I give my permission to the staff at Bright Beginnings West to administer medication as follows:

NAME OF CHILD: _____

TEACHER/CLASS: _____ DATE: _____

NAME OF MEDICATION: _____

*** *Note: All medication administered MUST be in its original container.*

DOSAGE:

_____TEASPOON/TABLESPOON _____ HOURS/TIMES PER DAY

DATE TO START: _____ DATE TO END: _____

REASON FOR MEDICATION: _____

_____

LAST DOSAGE GIVEN (date & time): _____

ANY ADVERSE EFFECT TO MEDICATION _____ YES _____ NO
(Drowsiness, Hyperactivity, Irritability, etc.)

IF YES, PLEASE STATE: _____

_____
Parent's Signature

STAFF USE (Please record time administered and initial):

Administered by/time: _____	Administered by/time: _____
Administered by/time: _____	Administered by/time: _____
Administered by/time: _____	Administered by/time: _____
Administered by/time: _____	Administered by/time: _____
Administered by/time: _____	Administered by/time: _____
Administered by/time: _____	Administered by/time: _____
Administered by/time: _____	Administered by/time: _____
Administered by/time: _____	Administered by/time: _____