

Permission to Administer Medicine



Child's Name _____

Physician's Name _____

Name of Medication _____

Dosage _____

Refrigerate Yes No

Other special conditions? (with liquids, etc.) _____

Time(s) to be given _____

Dates to be given _____

Parent's Signature _____

Date _____

Medicine Administration Record

	Monday	Tuesday	Wednesday	Thursday	Friday
Date					
Time					
Administered By: (initial)					