Permission to Administer Medication

For Growing Minds Learning Center

Child's Full Name_____

Name of Medication_____

Need to be refrigerated Yes or No

Dosage_____

Times to be given_____

Dates to be given_____

When did child last receive medication? _____

Parents Signature_____

Date_____

	Monday	Tuesday	Wednesday	Thursday	Friday
Date	_____	_____	_____	_____	_____
Time	_____	_____	_____	_____	_____
By	_____	_____	_____	_____	_____

Comments_____

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