

FCDC Medication Permission Sheet

Child's Name: _____ Date: _____

The following medication has been prescribed by a physician or requested to be given, by the parent. All medications must be clearly labeled and have a parent's permission slip signed.

Prescription Medicines

Medication: _____ Start Date: _____ End Date: _____
 Dosage: _____ Frequency: _____ Times to be given: _____
 Reason for giving: _____ Possible side effects: _____

Non-Prescription Medicines

Medication: _____ Reason for giving: _____
 Dosage: _____ Frequency: _____ Times to be given: _____
 Possible side effects: _____

 Parent or Guardian Signature

 Physician Signature

Date _____

Date _____

Center Staff MUST RECORD: Date, Time, Dosage & Signature

	Monday	Tuesday	Wednesday	Thursday	Friday
Date Time Dosage Signature Name					
Date Time Dosage Signature Name					
Date Time Dosage Signature Name					

Please place form in child's file when medication is complete.