



Name of Child: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Please X one of the following:

\_\_\_\_\_ Prescription      \_\_\_\_\_ Oral/Non-Prescription      \_\_\_\_\_ Topical/Non-Prescription

\_\_\_\_\_ Unanticipated Non-Prescription for mild symptoms (over the counter)

\_\_\_\_\_ Topical Non-Prescription (applied to open wound/broken skin - needs Doctor's signature)

\_\_\_\_\_ My Child has previously taken this medication

\_\_\_\_\_ My child has not previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan.

Dosage: \_\_\_\_\_

Medication Expiration Date: \_\_\_\_\_

Date(s) medication is to be given: \_\_\_\_\_

Times medication is to be given: \_\_\_\_\_

\_\_\_\_\_ Return home each day      \_\_\_\_\_ Medication kept at the school

Reason for medication: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Directions for storage: \_\_\_\_\_

Name and phone number of the prescribing health care practitioner:

\_\_\_\_\_

Health Care Practitioner Signature \_\_\_\_\_ Date \_\_\_\_\_

I give permission to authorize Little Treasures Schoolhouse staff to administer medication to my child as indicated above.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature ONLY for topical, non-prescription NOT applied to open wound/broken skill (i.e. diaper cream)

Administrator Intaking Medication \_\_\_\_\_

