Churchill Carling Daycare

ADMINISTRATION OF MEDICATION AUTHORIZATION FORM

****MEDICATION MUST BE IN ORIGINAL CONTAINER WITH CLEAR INSTRUCTIONS****

Name of Child: _____
Program: (please circle) **TOD** **JR.PRE** **SR. PRE**
Today's Date: _____
Name of Medication: _____
Reason for Medication: _____
Date Medication Began: _____
Date Medication Ends: _____
Amount of Medication to be given: _____
Time to be given: _____
Storage Procedures: _____
Possible Side Effects: _____

Parent's Signature: _____

Today's Date	Amount of Medication	Time Given	By Whom	Any Comments: