ALDRIDGE CHILD DEVELOPMENT CENTER

489 27TH. STREET
EAST MOLINE IL 61244

PHONE 755-5031

PERMISSION TO ADMINISTER MEDICATION

Child'sName:_____
_____

Name of
medication:_____
_
PrescriptionNumber:_____
_____
Reason for medication (i.e. ear
infection):_____

Time(s) of day medication is to be
administered:_____
_____
_____

Dosage:_____
_____

How many days will the medication be
administered:_____
List any side effects we should look
for:_____

_____
_____

Please administer the above named (prescribed) medication to my child as outlined above

_____

_____
Parent/Guardian Signature Date

Date	Signature of staff administering medication	Time medication given	Dose

SCHEDULE OF MEDICATIONS

Date	Signature of staff administering medication	Time medication given	Dose

Medication gone_____and container destroyed or _____sent home with parent
Staff Signature & Date_____