PERMISSION TO ADMINISTER MEDICATION

On-going Medication Form

I give permission for Kid's Hideout to administer the following doctor-prescribed medication to my child:

Child's Name: _____ Month: _____ Year:_____

Name of Medication: A. _____Dosage: _____Time: _____

Name of Medication: B. _____Dosage: _____Time: _____

Name of Medication: C. _____Dosage: _____Time: _____

Parent Signature _____ Date: _____

All medications must be in the original bottle/box with the label intact. The label must include the doctor's name, date and instructions/directions. Over-the-counter medications **CAN NOT** be administered without a written note from the doctor. A new "permission" form must be filled out every MONTH that your child needs the medication.

_____

STAFF USE ONLY:

Administered by: Medicine: Date: Time:

	a. ____ b. _____. c. _____		
	a. ____ b. _____. c. _____		
	a. ____ b. _____. c. _____		
	a. ____ b. _____. c. _____		
	a. ____ b. _____. c. _____		
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	a. ____ b. _____. c. _____		
	a. ____ b. _____. c. _____		
	a. ____ b. _____. c. _____		
	a. ____ b. _____. c. _____		

Once complete, please place this in the child's file. Thank you.