

(A separate authorization is required for each medication)

Child's Name:	Room:							
Medication:	Dose:	Pose:Time:						
			End Dat					
Route of Administration: □ Oral □Topical			□Inhaled	□Eye/E	□Eye/Ear/Nose □Other			
Reason for Medicat	ion:		Possib	le Side Eff	fects:			
Physician's Signat	ure:				Da	te:		
Clinic Address:	Phone:							
I			give permiss	ion for Sur	nflower Mo	ntessori	i and Γ	Day Care
	Parent		0 1					· J = •
To give the above Medication. Your child's first and last name								
Your	child's first and l	ast name						
Parent's Signature	Date:							
		For S	Staff to Comple	ete				
	Civa ma	diaina anly if you	1 00m 0mgwion 1 10g	to all awast	iona halow			
Give medicine <u>only</u> if you can answer <u>yes</u> to all questions bell Is the medication Administration Record Complete?						□Yes	Īг	No
Is the medication in a child-resistant container?						□Yes □No		
Is the Original Label/prescription label on the medication				ner?				
Is the Prescription of				□Yes	□No			
Is today the date be		□Yes				No		
Is the child's First a	er?	□Yes □No				No		
	Monday	Tuesda	ay Wed	nesday	Thursday		Friday	
Dose								
Date								
Time								
Teacher's Name								
Comments								
1	Monday Tuesda		y Wednesday		Thursday Friday		dov	
Dose	Wioliday	1 desur		viculesuay		Indisday		uay
Date								
Time								
Teacher's Name								
Comments								
Unused Medication r	eturn date to pa	rents:	'					