MEDICATION PERMISSION AND RECORD

Child's Name: _____

Medication Name: _____

Dosage Amount: _____

Time to be Given: _____

Date(s) to be Given: _____

Side Effects/Anticipated Reactions: _____

_____

Special Instructions (if applicable): _____

_____

_____

DATE	TIME	MEDICATION	AMOUNT	STAFF SIGNATURE

DATE	TIME	MEDICATION	AMOUNT	STAFF SIGNATURE

I,_____ have determined that the Ralston Schools Foundation Staff is competent to give or apply medication to my child.
Parent/Guardian's Name

I understand that the Child Care Center and School Age Only Center has the responsibility to assess the ability of staff to give or apply medications safely and may give or apply medication to my chid.

_____
Parent/Guardian's Signature

_____
Date