DISCOVERY DAYS PRESCHOOL

PERMISSION TO ADMINISTER PRESCRIPTION MEDICATION

Child's Name ______________________________ Date ______________

Medication ______________________________ Prescription #: __________

Dosage Amount ______________________ Time to Administer ____________

This medication is to be taken with ____________________________________

Should this medication be refrigerated? ❒ YES ❒ NO

Doctor's Name ___________________________ Office Phone ____________

I grant permission to my child's teacher, aide, or the Discovery Days Director to give the prescription medicine listed above to my child. I will provide the medication daily in its original prescription container.

______________________________________ ____________________

Parent / Guardian Signature Date

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