APPLES AND BOOKS LEARNING CENTER
MEDICATION PERMISSION SLIP

All medication requires a doctor's prescription. Clinician's order must be attached.

TO BE COMPLETED BY PARENT I give my permission to Apples and Books Learning Center and its staff to administer ________________________________, to my child ____________________________________, as follows:

Name of Medication — Child's First and Last Name

Start Date ____________ End Date ____________ Dosage amount_______________ Route to be given __________________
(oral/ears/eyes etc.)

Time to administer (i.e. 9AM or after lunch) ___________________________(First dose must be given at home)

Check what applies: ______Prescription ______ Over the counter

Condition for administering medicine ____

Storage of medicine: _____ refrigeration needed ______ no refrigeration needed

Other directions or possible adverse reactions, if any ____

Parent/Guardian Signature_________________________________ Date _____________ Cell # _________________________

TO BE COMPLETED BY THE CAREGIVER GIVING THE MEDICATION:

Date:	Time:	Amount:	Staff Member's Name:	Staff Member's Signature:
______	______	______	____________________________	____________________________
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Date medication returned to family: _____________________________ Staff Member's Signature:_____________________