APPLES AND BOOKS
LEARNING CENTER

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MEDICATION PERMISSION SLIP

Child's First Name_____ Last Name_____ Teacher_____

Name of medication _____

_____ Prescription _____ Non-prescription _____ Doctor's approval required

Condition for administering medicine _____

Amount to be administered_____ Start Date _____ Finish Date _____

Times to be administered_____

Refrigeration necessary _____ yes _____ no

Possible adverse reactions _____

Staff member authorized to administer medication _____

Telephone number and name of parent to reach for questions _____

Parents Authorizations Signature_____

Date	Time	Amount	Adverse reactions observed	Staff member's initials