Apples and Books Learning Center

1036 ROUTE 202
BRANCHBURG, NJ 08876
(908) 429-4275
(908) 429-0841 fax
www.applesbooks.com

MEDICATION PERMISSION SLIP

TO BE COMPLETED BY PARENT I give my permission to Apples and Books Learning Center and its staff to give or apply the medication _____, to my child _____, as follows:
Name of Medication Child's First and Last Name

Date to begin giving medicine _____ Last date to give medicine _____ Dosage amount_____

Time medicine should be given (i.e. 9AM or after lunch) _____

Check what applies: _____ Prescription _____ Over the counter _____ Clinician's order is attached

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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