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:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Date medication returned to family: _____ Staff Member's Signature:_____