MEDICATION AUTHORIZATION

I authorize the administration of _____
(medication)
to _____ by _____
(child's name) (name of day nursery)

Start Date: _____ End Date: _____

Dosage: _____Time(s) of Administration_____

Storage: _____Side Effects: _____

Stop medication if the following reaction (s) is observed: _____
_____

Date: _____ Parent Signature: _____

Administration Record

Date	Time Given	Amount Given	Staff Signature	2nd Staff Signature (if applicable)	Comments/Observations