FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY
PHONE: 973-377-4945
FAX: 973-377-8534

Medication Permission Form:
Authorization to Give Medication in Childcare Center or School

Child's Name: _____ Birthdate: _____ Classroom: _____

Today's Date: _____ Continue through (date): _____

Name of Medication(s): _____

Dose & time to be given: _____
(write in specific times)

If prescribed on an as needed (PRN) basis, give for these symptoms: _____

_____
(example: for fever, pain, etc.)

Side effects, if any: _____

Please indicate if this medication is:

☐ **PRESCRIPTION MEDICATION**
Is the medication in the original container or box with the prescription label and instructions?
☐ YES (Physician Authorization is not required)
☐ NO. See Physician's Authorization requirement below *. This medication may not be given unless the required information is provided.

☐ **NON-PRESCRIPTION MEDICATION**
For **all** non-prescription medications, you must provide a completed Physician's Authorization* (see below).

I hereby give permission for the administration of the medication described above by the staff of the F.M. Kirby Children's Center, and have provided the completed Physician's Authorization if necessary.

Parent/Guardian Signature: _____ Date: _____

Parent's/Guardian's Printed Name: _____

*** PHYSICIAN'S AUTHORIZATION**
You must provide **either** of the following forms of authorization, which must be signed by a physician:

☐ Physician's Signature: _____ Physician's Stamp: _____
☐ See attached, signed physician's authorization document

OTHER REQUIREMENTS
*Children with asthma medications (inhalers/nebulizers) will need an Asthma Treatment Plan completed
*Children with severe allergies/epi-pens will need a Food Allergy Action plan completed.

All forms are valid for one year from date of health provider's signature.

(Please see other side)