Medication Release Form

Please Note that this form is only good for ONE WEEK.
This is to insure the safety of your child(ren) as medications do change.

Name of Child:

Age: 5

Name of Medication:

Condition Being Treated:

Date(s) Medication is to be Given:

Time(s) Medications is to be Given:

Dosage / Amount to be Given:

Method of Administration: *Please Select One From The Drop Down Options*

Possible Side Effects or Interaction with Other Drugs:

I hereby give permission for the provider to administer this medication according to the instructions above. I agree that the provider will not be held liable for any illness or injury resulting from the administration of this medication and will not be held responsible for the reimbursement of any medical expenses resulting from such action. By typing your name you are signing this document.

Name Of Guardian: **Date:**

Name of Child:

Name of Medication:

Condition Being Treated:

Date(s) Medication is to be Given:

Time(s) Medications is to be Given:

Dosage / Amount to be Given:

Method of Administration: *Please Select One From The Drop Down Options*

Date	Time	Dosage	Administered By	Reactions	Administration Errors