PHYSICIAN'S ORDER FOR
ADMINISTRATION OF ORAL MEDICATION BY CENTER PERSONNEL

Child's Name _____ Child's Address _____

I have prescribed the following medication for this child and request that dosage falling during child care hours be administered by Center personnel. (***NOTE***: Authorization is needed for non-prescription medications, also.)

MEDICATION: _____

Condition for which prescribed: _____

Possible Side Effects _____

Instructions for use: _____

Dosage: _____ Time: _____

Frequency: _____ How Long: _____
(number of days)

Date: _____ Physician's Signature: _____

Address: _____

Phone: _____

Pharmacy: _____ Phone: _____ Rx. No. _____

PARENTAL PERMISSION

I have delivered the above medication in the original container to the center and request that it be given to my child as prescribed.

I release _____ personnel from any liability in relation
(name of center)
to the administration of this medication at the center.

_____ _____

Date: Signature of Parent or Guardian

CENTER STAFF: Fill in the date and time, then initial whenever dispensing medicine.

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY

DISPOSITION OF MEDICINE: Returned to Parents: _____ Date: _____

NOTE: Please place this form in the child's folder when medication is complete.