Medication Administration
Parental Permission Slip
For Prescription Medications

I, the parent of __________________ on this date ____/____/____
Request the Head Start/Early Head Start staff of ______________
county to administer the following medication(s) to my child.

Name of Medication ___________________________________
Reason for Medication _________________________________
Amount of Medication to be given _________________________
Route Medication is to be given __________________________
(mouth, eye, ear, skin, etc.)
Time(s) Medication is to be given__________________________
Number of days Medication is to be given __________________
Storage and Disposal Instructions _________________________

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Medication Administration
Parental Permission Slip
For Non-Prescription Medications

I, the parent of __________________ on this date ____/____/____
Request the Head Start/Early Head Start staff of ______________
county to administer the following medication(s) to my child.

Name of Medication ___________________________________
Reason for Medication _________________________________
Amount of Medication to be given _________________________
Route Medication is to be given __________________________
(mouth, eye, ear, skin, etc.)
Time(s) Medication is to be given__________________________
Number of days Medication is to be given __________________
Storage and Disposal Instructions _________________________

Parents Signature ____

Physicians Signature ____