Permission to Administer Medication

Child's Name ____

Diagnosis ____

Medication and Prescription Number ______________________________

Physician's Name ____

Physician's Phone Number ____________________________________

Dosage of Medication ____

Time to be Administered ____________________

By Whom ______________________________

Number of day's __________________________

Number of doses __________________________

I am providing the above prescription medication to be given to my child by a trained Head Start employee.

Parent/Guardian Signature ____________________________________

Date ________________________________

Adverse Reactions:

Desired results of receiving medication:

I approve of Head Start administering this medication at school.

Physician's Signature ____

Date ________________________________