PERMISSION FOR MEDICATION

Little Mavericks Learning Center

Child's Name_____DOB_____

Teacher_____

Primary Care Provider_____

Medication_____

Dosage_____ _____

Dosage_____ Route_____

Purpose of medication_____

Time of day medication to be given_____

Possible side effects_____

Anticipated number of days medication needed to be given at LMLC_____

_____ _____

Date Signature of person with Prescriptive Authority

Parent/Guardian

I herby give permission for _____to take the above prescription medication at Little Mavericks Learning Center as ordered. I understand that it is my responsibility to furnish this medication.

_____ _____

Date Signature of parent or guardian