# Permission to Administer Medications

**Child's name:** _____ **Date:** _____ **DOB:** ___/___/___
**D/ M/ Y**

**I hereby give my permission to the staff of Cloverdale Out of School Care to administer**

_____**to my child.**
**(Name of medication)**

***Please write the exact dosage & times the medication is required as indicated on the medication bottle. Please specify any changes that would occur on full days of care i.e. summer, Prod Day's, etc.***

**Dosage:** _____ **Time(s) to be given:** _____

**Special instructions & storage:** _____

_____

_____

**Start date:** _____ **End date:** _____

**Possible side effects for the medication:** _____

_____

**Inhalers & Epi-pens: A Health Care Action Plan is required.**

_____ _____

**Parent / Guardian's sign** **Date**

To be completed by the child care provider

**I,** _____ **And** _____ **(care provider's name) agree to administer**

**the medication according to the instructions provided by the Parent / Guardian above.**

**Care provider's signature:** _____

**Care provider's signature:** _____

Medication Record
(to be completed by child care provider when the medication is given)

| Date | Time | Dosage | Comments | Given by (staff name) |
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