Medication Administration Packet

Authorization to Give Medicine
PAGE 1—TO BE COMPLETED BY PARENT/GUARDIAN

CHILD'S INFORMATION

Champlain Valley Christian School
Name of Facility/School

__/__/__
Today's Date

Name of Child (First and Last)

__/__/__
Date of Birth

Name of Medicine _____

Reason medicine is needed during school hours _____

Dose _____ Route _____

Time to give medicine _____

Additional instructions _____

Date to start medicine ____/____/____ Stop date ____/____/____

Known side effects of medicine _____

Plan of management of side effects _____

Child allergies _____

PRESCRIBER'S INFORMATION

Prescribing Health Professional's Name

Phone Number

PERMISSION TO GIVE MEDICINE

I hereby give permission for the facility/school to administer medicine as prescribed above. **I also give permission for the caregiver/teacher to contact the prescribing health professional about the administration of this medicine. I have administered at least one dose of medicine to my child without adverse effects.**

Parent or Guardian Name (Print)

Parent or Guardian Signature

Address

Home Phone Number Work Phone Number Cell Phone Number