PERMISSION TO ADMINISTER MEDICATION

I, _____, hereby give my consent for the Grand
(Parent/Guardian Signature)
Traverse Band Early Head Start/Head Start/GSRP Program (s) to administer medication to my child,

_____, from _____ to _____.
(Child's Name) (Date) (Date)

Reason the medication is being given:_____.

Check the label on the bottle for the following information and record below:

Child's name:_____

Today's date:_____

Name of medication:_____

Amount of dose needed:_____

Frequency of dose to be given:_____

Time(s) of day for administration:_____

Name of Doctor:_____

Special storage instruction given:_____

Expiration date of medication, if the medication is for repeated use over an extended period of time:_____

Medication has safety lock closure: Yes_____ No_____

Side effects to expect and actions to take:_____

_____

PLEASE DO NOT WRITE BELOW THIS LINE_____.

Name of person/title administering meds.	Date	Identify name of medication	Dose given	Time given

Notes/Observed side effects: (include date, time and name of staff person)

_____

_____

_____