# FCDC Medication Permission Sheet

Child's Name: _____ Date: _____

The following medication has been prescribed by a physician or requested to be given, by the parent. All medications must be clearly labeled and have a parent's permission slip signed.

## Prescription Medicines

☐ Medication: _____ Start Date: _____ End Date: _____

Dosage: _____ Frequency: _____ Times to be given: _____

Reason for giving: _____ Possible side effects: _____

## Non-Prescription Medicines

☐ Medication: _____ Reason for giving: _____

Dosage: _____ Frequency: _____ Times to be given: _____

Possible side effects: _____

_____ _____

Parent or Guardian Signature Physician Signature

Date _____ Date _____

## Center Staff MUST RECORD: Date, Time, Dosage & Signature

| | Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|---|
| Date<br>Time<br>Dosage<br>Signature<br>Name | | | | | |
| Date<br>Time<br>Dosage<br>Signature<br>Name | | | | | |
| Date<br>Time<br>Dosage<br>Signature<br>Name | | | | | |

*Please place form in child's file when medication is complete.*