Medical Administration, Authorization and Log

Name of Child:_____

Medication Prescribed:_____ Reason:_____

Administration Method:_____
(oral, topical, etc.)

Frequency of Administration:_____ Dosage:_____

Beginning Date of Medication:_____ End Date of Medication:_____

all medication must be kept in its original containers

Any other details pertaining to medication or dosage that will be helpful for us to know:_____

_____

I give permission for **StartWrite Preschool** to administer the above medication to my child as explained above.

_____

Parent's Name (Printed) Parent Signature Relation to Child Date

Medication Log

Date	Time	Medication	Amount	Given By