

Child Name: _____

Monthly Medicine Record: Month _____

Year _____

Child Known Allergies: _____

Parent Permission to give medicine: I give my permission for the child care business to give the following medicine(s) to my child.

Date: _____ Parent Signature Giving Permission: _____	Name of medicine on the label: _____	Medicine dose on the label: _____	Time of day medicine is to be given at child care: ¹ _____	Route of medicine as on the label: _____	Possible side effects: _____	Required storage: <input type="checkbox"/> Refrigerate <input type="checkbox"/> Refrigeration not required
<input type="checkbox"/> Medicine is doctor approved and doctor authorization form on file at child care						
Reason medicine needed: _____						
Special instructions for giving medicine: ² _____						
Beginning date for medicine: _____						
Ending date for medicine: _____						

Date: _____ Parent Signature Giving Permission: _____	Name of medicine on the label: _____	Medicine dose on the label: _____	Time of day medicine is to be given at child care: _____	Route of medicine as on the label: _____	Possible side effects: _____	Required storage: <input type="checkbox"/> Refrigerate <input type="checkbox"/> Refrigeration not required
<input type="checkbox"/> Medicine is doctor approved and doctor authorization form on file at child care						
Reason medicine needed: _____						
Special instructions for giving medicine: _____						
Beginning date for medicine: _____						
Ending date for medicine: _____						

Date: _____ Parent Signature Giving Permission: _____	Name of medicine on the label: _____	Medicine dose on the label: _____	Time of day medicine is to be given at child care: _____	Route of medicine as on the label: _____	Possible side effects: _____	Required storage: <input type="checkbox"/> Refrigerate <input type="checkbox"/> Refrigeration not required
<input type="checkbox"/> Medicine is doctor approved and doctor authorization form on file at child care						
Reason medicine needed: _____						
Special instructions for giving medicine: _____						
Beginning date for medicine: _____						
Ending date for medicine: _____						

Parent permission to contact pharmacy and physician: I give my permission for the child care business to contact my child's pharmacy and physician should questions arise or a situation occur that involves my child and the medication.

Parent Name (print): _____ Parent Signature: _____ Date: _____

¹ The time of day for the medicine needs to be consistent between home, child care and other programs where the child is located like school. Ask the parent when the medicine is given at home so medicine doses may be evenly spaced for maximum benefit.

² The medicine may need to be given before meals, after meals, with food, with a specific liquid (water or milk). All instructions should be written on the medicine label or instructions. When in doubt, call the pharmacy where prescription medicine was dispensed.