

Medication Permission Form

(One sheet per child per medication)

Child's Name: _____ DOB _____

Dr Name / Surgery: _____

Medication: _____ Dosage: _____ Route: _____

Time of day medication is to be given: 1: _____ 2: _____

3: _____ 4: _____ 5: _____ 6: _____

Possible side-effects/allergies: _____

Anticipated number of day medication will be given at nursery _____

Parent/Guardian

I hereby give my permission for my child to take the above referenced prescription medication at Little Acorns as above. I understand that it is my responsibility to furnish this medication in its original container.

Signature of Parent/Guardian _____ Date: _____

Staff Signature _____ Date: _____

(on behalf of Little Acorns Day Nursery)

