

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: <sup>1</sup>	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: <sup>2</sup>		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: \_\_\_\_\_

<sup>1</sup> 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.

<sup>2</sup> 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.