ScribbleTime
A Center for Early Learning
Infant Toddler Preschool

Authorization for Medication

Form 3.8.A

Name of Child: _____

Name of Medication: _____ Prescription: Yes No

Dosage: _____

Date(s) medication to be given: _____

Times medication to be given: _____

Reason for medication: _____

Possible side effects: _____

Name of Physician: _____ Phone Number: _____

Directions for storage: _____

Special Instructions (i.e., taken with food): _____

_____

I, _____ (parent or guardian), give permission to authorized staff members of ScribbleTime A Center for Early Learning, LLC to administer medication to my child as indicated above.

_____ _____

Parent / Guardian Signature Date

For Non-Prescription Medication

_____ _____

Physician Signature Date

☐ Copied to the Emergency Evacuation File in the Medicine Cabinet Employee Initials _____

To be filed in the Child's Record.