MEDICATION PERMISSION FORM
PRESCRIPTION AND/OR OVER-THE-COUNTER MEDICATIONS

This form must be returned to the Cox Children's Center signed by both you and your child's physician in order for the medication to be administered by the Cox Children's Center Staff.

Child's First Name: _____ Child's Last Name: _____

Date of Birth: _____ Classroom: _____

TO BE COMPLETED BY PHYSICIAN

_____ is under medical care for _____
(Child's Name)

And the following medication(s) is/are required:

Name of Medication: _____ Method of Administering _____

Dosage _____ Time to be given _____

Side Effects: _____

Dates Medication Should be Administered _____

Name of Medication: _____ Method of Administering _____

Dosage _____ Time to be given _____

Side Effects: _____

Dates Medication Should be Administered _____

Signature of Physician _____ Date _____
Printed Name of Physician _____ Address _____
Phone Number _____ Fax Number _____

TO BE COMPLETED BY PARENT OF LEGAL GUARDIAN

I hereby request that my child receive from assigned school personnel the above medication(s) as directed by the physician.
The medication will be sent to school in an appropriately labeled bottle/container from the pharmacy. **The bottle should be labeled with the first and last name of the child, date filled, expiration date, manufacturer's instructions or prescription, administration and storage instructions.**
I will assume the responsibility of bringing the medication or assign this responsibility to an adult designee.
I will notify the school in writing if the medication is discontinued.
I will obtain a written physician's order if the medication dosage is changed.
I give permission for the center staff to contact the above physician in regard to any medication concerns.

TO BE COMPLETED BY CENTER STAFF AND PARENT OR LEGAL GUARDIAN

Pills have been counted in front of parent. Number of pills provided to the center is _____.

Center Staff Signature _____ Date _____

Parent/Guardian Signature _____ Date _____