

# Medication Record/Permission

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Educator's Name: \_\_\_\_\_

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I \_\_\_\_\_ give permission for Educator \_\_\_\_\_ to administer the following  
*Name of Parent/Guardian* *Name of Educator*

medication for the child, \_\_\_\_\_ as detailed below. Parent/Guardian Signature \_\_\_\_\_  
*Name of Child*

To be completed by parent/guardian						To be completed by Educator						
Name of medication	Last administered		To be administered		Dosage to be administered	Method of administration eg before or after food	Signature of parent/guardian	Medication administered		Dosage administered	Method of administration	Signed by educator
	Time	Date DDMM	Time	Date DDMM				Time	Date DDMM			