Permission to Administer Medication

Child's Name: ____

Reason for Medicine: ____

Name of Medicine: ____

Storage requirements: ____

Dosage: ____

Times to be administered: _____________________________________

I give permission to Stepping Stones to administer medicine in accordance with the details above.

I accept responsibility that the medication I have provided is appropriate for my child

Parent's name: ____

Parent's signature: ____

Date: ____

Administered by: ____

Staff name: ____