stepping stones
After school CLUB

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: _____