Sioux Valley

CHILD CARE CENTER

Medication Authorization

Name of Child _____

Date(s) _____

Name of Medication	Dosage	Time to be Given	For What Illness	Storage (✔) Refrig.	Cabinet

I hereby authorize the designated staff member of Sioux Valley Hospital Child Care Center to administer the following medication(s) to my child, _____ on the following date(s) _____. I assume the full responsibility for any possible consequences due to the administration of the above listed drug(s).

Signed _____
(Signature of Parent)

Ext. # / Phone # _____

RECORD OF MEDICATION ADMINISTRATION

Date	Name of Medication	Dosage	Time Given	Given By	Verified By
			AM PM		
			AM PM		
			AM PM		
			AM PM		
			AM PM		

Comments

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