Pediatric Associates of Mt. Carmel, Inc

Established 1972

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MEDICATION PERMISSION FORM

I/We are the parents of: _____

Address: _____

Phone: _____ School/Day Care: _____

I authorize _____ to administer the following drugs to my son/daughter.

School/Day Care

I will deliver the medication to school/daycare and submit to school/daycare personnel a written statement signed by my physician if any of the information provided by the physician changes.

Parent's Signature _____

It is necessary for the aforementioned child to take medication during school/daycare hours. I will notify the school/daycare if the medication, the dosage or the procedure is to be changed or eliminated.

Name of medication_____ dosage_____

Directions_____

Beginning date: _____ Ending date:_____

Any special instructions _____

Physician signature _____ Date _____