Little Miracles Daycare

Medication Authorization Form

If your child needs medication while at Little Miracles Daycare, please complete this form before bringing the medication to school.

CHILD'S INFORMATION

First Name	Middle	Last Name
Date of Birth	Gender	Parent / Guardian Name(s):
Primary Phone #		Secondary Phone #
Child's Home Address		

MEDICATION DETAILS

Medication Name:_____

Why is your child taking the medication?_____

How much should be given?_____

How should it be given? (by mouth, cream, inhaler, etc.)_____

What time(s) should it be given?_____

Dates medication should be given: FROM_____ TO_____

RX #: _____

Medication Name:_____

Why is your child taking the medication?_____

How much should be given?_____

How should it be given? (by mouth, cream, inhaler, etc.)_____

What time(s) should it be given?_____

Dates medication should be given: FROM_____ TO_____

RX #: _____

Medication Name:_____

Why is your child taking the medication?_____

How much should be given?_____

How should it be given? (by mouth, cream, inhaler, etc.)_____

What time(s) should it be given?_____

Dates medication should be given: FROM_____ TO_____

RX #: _____

Medication Name:_____

Why is your child taking the medication?_____

How much should be given?_____

How should it be given? (by mouth, cream, inhaler, etc.)_____

What time(s) should it be given?_____

Dates medication should be given: FROM_____ TO_____

RX #: _____

Medication Name:_____

Why is your child taking the medication?_____

How much should be given?_____

How should it be given? (by mouth, cream, inhaler, etc.)_____

What time(s) should it be given?_____

Dates medication should be given: FROM_____ TO_____

RX #: _____

PARENT / GUARDIAN PERMISSION

I give permission for Little Miracles Daycare staff to give this medication to my child as instructed above.

Parent / Gradian Name (print):	
Parent / Guardian Signature:	Date
Best Phone Number:	