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(201) 348-2754
(201) 348-5774 Facsimile

510-35th Street
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PERMISSION TO GIVE MEDICATION IN CHILD CARE

The following information is to be completed by the child's health care provider:

Child's Name: _____ **Birthdate:** _____ **Wt:** _____

Medication: _____ **Allergies:** _____

(Include food and/or medication allergies)

Dosage: _____ **Route:** _____

Time of day medication is to be given: _____

Purpose of Medication: _____

Special Instructions: _____

Possible Side Effects: _____

Start Date: _____ **End Date:** _____

Signature of Health Care Provider

Phone Number

Date

PHYSICIAN STAMP REQUIRED

THE FOLLOWING IS TO BE COMPLETED BY THE PARENT OR GUARDIAN:

I hereby give permission for my child _____, to receive the above medication, according to the listed directions and cautions, from the Child Care Director, or the Child Care Director designee. In confirm that I have given at least one dose of the medication without any evidence of side effects or adverse reactions. I understand that it is my responsibility to supply the appropriate measuring device needed to give the accurate dose of the medicine. I authorize the Director or Director's Designee to contact the pharmacist or health care provider for more information about this drug, if necessary. I also authorize the Director or the Director's Designee to contact the health care provider regarding my child's health, if necessary.

I usually do the following to make giving medication to my child easier: _____

Amount of medication brought to Child Care: _____

DATE

SIGNATURE OF PARENT/GUARDIAN

Date and amount of medication returned to Parent: _____

SIGNATURE OF DIRECTOR/DIRECTOR DESIGNEE

SIGNATURE OF PARENT/GUARDIAN

PLEASE USE ONE FORM PER MEDICATION

10:122-7.5 Administration and control of prescription medicines and health care procedures

SCHOOL YEAR: _____