Permission to Administer Medication Page 1							
Child's Name	Birthday	Today's Date					
Parent's Name	Cell Number	er:					
Name of Medication 1:		Expiration Date:					
Name of Medication 2:		Expiration Date:					
Name of Medication 3:		Expiration Date:					
Reason for Medication/s:							
Dose Med 1:							
Dose Med 2:							
Dose Med 3:							
Date to Start:	Date to Stop:						
Prescribing Health Care Provide	er:						
Prescribing Doctor Phone Numb	per:						
	t had any allergic or unexpected reaction from						
I authorize Noah's Ark Childcare	e Services, Inc. personnel to administer the	medication named below to my child in					

the manner as stated. I release any liability in relation to the administration of this medication. I also acknowledge that I, the parent/guardian, have given the first dose of this medication without any allergic or unexpected reactions.

This page may be copied for continued dosing.

Date, Time, Dosage, Person giving medication initials and any reactions noticed

Med/s	Date	Time	Dose	Initials	Observation of any reactions

Permission to Administer Medication Additional Pages

Page 1 is required to be attached to all additional pages

Child's Name			Birthday		Today's Date				
Parent's Name				Cell Number:					
Date, Time, Dosage, Person giving medication initials and any reactions noticed									
Med/s	Date	Time	Dose	Initials	Observation of any reactions				