Beacon of Hope Child Care and Learning Center
Child Care Medication Form

Date _____

Child's Name _____

Teacher _____

Medication _____

Medication to begin_____20____and

end_____20_____

Amount to be given and

when_____

*****Last time medication was administered at

home_____

I give my permission for the above medication to be given to my child as I have prescribed above.

Parents

Signature_____

Medication Administration Record

Child's Name/Date Time Amt.Given Teacher's Initial

_____

_____

_____

ATTENTION: When this is completed, please place in child's file.

Additional forms may be obtained in the office.