Long-Term Medication Permission Form – Prescription and non-prescription medications

(Medications over One Week)

Name:_____ Today's Date:_____

Expiration Date for the Administering Medication:_____ Dosage Amount: _____
Time(s)/Day(s) to be administered:_____

I give my approval for Discovery Place to be administer the following medication to my child which I have provided:

Name of Medication*: _____

*Discovery Place will need to obtain and follow written instructions from a licensed Physician or dentist prior to administering **each prescription medicine**. Medicine with the child's name and current prescription information on the label constitutes instructions.

Purpose of Medication:_____
_____
_____

Specific Instructions: _____
_____
_____

Parent/Guardian Signature:_____ Date: _____

For Office/Staff Use Only

Medication was administered the following days and times:

Date:	Time:	Staff Initials:
Date:	Time:	Staff Initials:
Date:	Time:	Staff Initials:
Date:	Time:	Staff Initials:
Date:	Time:	Staff Initials:
Date:	Time:	Staff Initials:
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