INDIVIDUAL PERMISSION FOR MEDICATION OR HEALTH CARE PROCEDURE

Child's Name:_____

Child's Condition:

___ Cold	___ Sore Throat	___ Rash	___Ear Infect.	___ Headache	___ Nausea	___ Stomach Ache
___ Injury	___ Allergy	Other _____				

Name of medication/procedure: _____

_____ Prescription _____ Non-Prescription _____ Doctor's Approval required

Dosage to be administered: _____ _____

Time intervals: _____

Dates to be administered: From _____ To_____ Refrigeration necessary: ____ Yes ____ No

Special Instructions or precautions: _____

_____

Possible adverse reactions: _____

_____

I authorize the administration of the above medication, by a Kidz Space staff supervisor or assistant supervisor, to my child.

_____ _____

Parent Signature Date

For Kidz Space Administration use only:

Date(s) Administered	Time(s) Administered	Adverse Reaction Observed	Staff Member Initials