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 Wee Kids ELC staff supervisor or assistant supervisor, to my child.

____ ____________________________

Parent Signature Date

For Wee Kids Administration use only:

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