Giggles' Child Development Center Master Card Information

Medication Authorization Form

Medicine Must Be In Its Original Container

Child's Name: _____Medication Name: _____

Dosage Amount: _____ Time to be Given: _____

Date(s) to be Given: _____ Side Effects/Reactions:_____

Special Instructions (if applicable):

_____

_____

_____

Parent's Signature_____ Date_____

***If all information is not filled in completely, medication will not be given.**

Administration Documentation

Date Given	Time Given	Dosage Given	Staff Signature

***Maintenance medication authorization shall be updated as changes occur or at least every three months.**