Cradle 2 Crayons Daycare & Preschool

Request for Administration of OTC Medication

Child's Name : _____

Child's Weight: _____

Name of Medication: _____

Dosage: _____

Route (by mouth, tube, suppository): _____

How often to administer: _____

Last dose prior to drop off (date,time): _____

I, _____, give Lynn Goodman, permission to administer the above prescription medication to _____ in the above dosage, route, and frequency. I understand all medications have side effects and I am aware that the provider will report any side effects to me immediately.

DATE	TIME	DOSAGE	PROVIDER SIGNATURE