Faith Lutheran Learning Center
Permission for Administration of Medication

Child's Name: _____
Name of Medication: _____
Prescribed Dosage: _____
Dates medication is to be given: _____
Time medication is to be given: _____
Parent's Name & Phone Number: _____
Comments: _____

Date: _____ Parent Signature: _____
Date: _____ Parent Signature: _____
Date: _____ Parent Signature: _____
Date: _____ Parent Signature: _____
Date: _____ Parent Signature: _____
Date: _____ Parent Signature: _____
Date: _____ Parent Signature: _____
Date: _____ Parent Signature: _____
Date: _____ Parent Signature: _____
Date: _____ Parent Signature: _____

Date: _____ Time Given: _____ Teacher Initials: _____
Date: _____ Time Given: _____ Teacher Initials: _____
Date: _____ Time Given: _____ Teacher Initials: _____
Date: _____ Time Given: _____ Teacher Initials: _____
Date: _____ Time Given: _____ Teacher Initials: _____
Date: _____ Time Given: _____ Teacher Initials: _____
Date: _____ Time Given: _____ Teacher Initials: _____
Date: _____ Time Given: _____ Teacher Initials: _____
Date: _____ Time Given: _____ Teacher Initials: _____
Date: _____ Time Given: _____ Teacher Initials: _____