Medication Permission Slip

Name of child: _____ Date: _____

Name of medication: _____

Dosage: _____

How often to be given: _____

Time last given? _____

Route? (by mouth, topical, or inhaled) _____

Special Instructions: _____

_____ _____

Signature (Parent or guardian) Date

This permission expires on _____

(Date)

Date given	Time given	By (initial)

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