

Medication Release Form

Please Write Clearly

Name of Child: _____ Age: _____

Name of Medication: _____

Condition Being Treated: _____

Date(s) Medication is to be Given: _____

Time(s) Medication is to be Given: _____

Dosage / Amount to be Given: _____

Method of Administration (for example, orally, topically, nasally, etc.): _____

Possible Side Effects or Interactions with Other Drugs: _____

I hereby give my permission for the staff to administer this medication according to the instructions above. I agree that the staff will not be held liable for any illness or injury resulting from the administration of this medication, and will not be held responsible for the reimbursement of any medical expenses resulting from such action.

_____/_____/_____
Signature of Parent or Guardian Date

Medication Administration Record					
Date	Time	Dosage	Administered By	Reactions	Administration Errors
____/____/____					
____/____/____					
____/____/____					
____/____/____					
____/____/____					
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This form is provided as a technical assistance suggestion only. Providers are not required to use this form.