CONSENT FOR MEDICATION

NO MEDICATION WILL BE GIVEN BY STAFF WITHOUT AUTHORIZATION FROM DOCTOR AND WRITTEN DIRECTION OF THE PARENT.

CHILD'S NAME _____ **DATE** _____

I give GEORGETOWN UNIVERSITY LAW CENTER CHILD CARE CENTER my permission to administer the following drugs and medication with the authority of my physician.

DRUG NAME AND/OR PRESCRIPTION NO. _____

DOSAGE TO BE GIVEN _____ **TIMES TO BE GIVEN** _____

START DATE: _____ **STOP DATE:** _____

SPECIAL INSTRUCTIONS _____

_____

I understand that this medication will be returned to the parent each evening.

Doctor's Signature _____
(for over the counter medication)

Parent's Signature _____

DATE	NAME OF MEDICATION	TIME GIVEN	DOSE GIVEN	STAFF SIGNATURE