DISCOVERY ISLE®
CHILD DEVELOPMENT CENTER

ADMINISTRATION OF MEDICINE AUTHORIZATION

Child's Name: _____ Date: _____

I authorize the staff of Discovery Isle Child Development Center to administer medication to my child as follows:

_____ _____
Name of Medication Exact Dosage

_____ _____
Time(s) Medicine is to be given Beginning and ending dates Medicine is to be given

Medicine ☐ **DOES** ☐ **DOES NOT** need to be refrigerated.

_____
Parent's Signature

MEDICINE LOG

Date: _____ Time: _____ _____ Initial: _____

Date: _____ Time: _____ _____ Initial: _____

Date: _____ Time: _____ _____ Initial: _____

Date: _____ Time: _____ _____ Initial: _____

Date: _____ Time: _____ _____ Initial: _____

NOTE: This form can be used for up to one week of medication at a time.