JOYFUL JOURNEYS CEC

AUTHORIZATION FOR MEDICATION

ATTN PARENTS: FORM MUST BE COMPLETES IN ITS ENTIRETY BEFORE THE

CENTER CAN DISPENCE ANY MEDICATION.

CHILD'S FULL NAME: _____

NAME OF MEDICATION: _____

RESON FOR MEDICATION: _____

(Medication will not be given on an "as needed" basis, specifics must be provided.)
For example: "For teething, please give as needed if child has a temp 99 or above and fussy."

TIME OF MEDICATION TO BE GIVEN: (___)10AM (___)2PM

AMOUNT OF MEDICATION TO BE GIVEN: _____

DATES TO BE GIVEN: _____

(DATE CANNOT EXCEED TWO WEEKS WITHOUT NOTE FROM PHYSICIAN)

_____ _____
PARENT SIGNATURE DATE

DATE	TIME GIVEN	AMOUNT	REACTIONS	GIVEN BY
_____	10 2	_____	_____	_____
_____	10 2	_____	_____	_____
_____	10 2	_____	_____	_____
_____	10 2	_____	_____	_____
_____	10 2	_____	_____	_____
_____	10 2	_____	_____	_____
_____	10 2	_____	_____	_____
_____	10 2	_____	_____	_____
_____	10 2	_____	_____	_____
_____	10 2	_____	_____	_____