



## Authorization For Medication Form

I hereby authorize LILLIPUT EARLY CHILDHOOD CENTER to administer the following medication to my child \_\_\_\_\_  
( name of child )

Medication \_\_\_\_\_ Prescription \_\_\_\_\_

Dosage \_\_\_\_\_ Non-prescription \_\_\_\_\_

When to be given (time): \_\_\_\_\_ and for \_\_\_\_\_ days.

Parents signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Date	Dosage	Time	Signature of Staff Person
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

This form must be filed in the child's record after the course of medication has been completed.