

**Lilliput Early Childhood Center Inc.
18 & 770 Grafton Street
Shrewsbury, Ma. 01545
(508) 842-0430 & 757-1900**

AUTHORIZATION FOR MEDICATION

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: _____

Doctor's Signature: _____

Date: _____

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.