Kindertown
CHILD CARE & LEARNING CENTRE

A place for your child to grow and for you, peace of mind

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MEDICATION ADMINISTRATION CONSENT FORM

_____ _____
Child's Name **Date**

_____ _____
Illness/Symptoms **Medication**

_____ _____
Doctor's Name **Medication Expiry Date**

_____ _____ **Time to be administered:** _____
Dosage **Storage Requirements** _____

_____ _____
Parent Signature **Date**

Does Medication Need to be sent home daily: Yes□ No□

Week One

Date	Time Given	Staff Signature

Week Two

Date	Time Given	Staff Signature