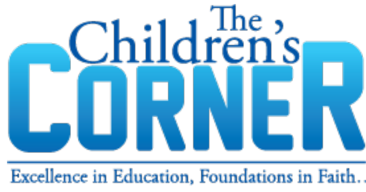
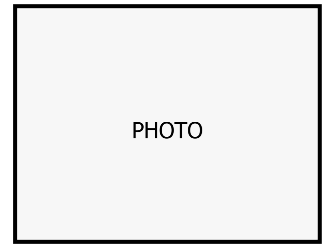
Today's Date: ________________

Child's Class: __________________




# MEDICATION AUTHORIZATION

Please return completed forms to TCCoffice@libertycorner.org.

I request and authorize The Children's Corner to give my child _________________________ the following medicine in the amount and at the times specified below:

**Name of Medication**: _________________________________

Dosage/Amount: ___________________________________

Please Indicate Medication Time(s): ☐ Specific Time(s) ___________________ ☐ As Needed______________

Does the medication need to be refrigerated? ☐ YES ☐ NO ______________

Condition for which the medication is being issued: ___________________________________________

Any adverse effect the medication can have or has had on your child: _______________________________

_____________________________________________________________________________________

The medication is to be continued through the following date: ____________________________________

Name and phone number of prescribing physician: ____________________________________________

**Name of Medication**: _________________________________

Dosage/Amount: ___________________________________

Please Indicate Medication Time(s): ☐ Specific Time(s) ___________________ ☐ As Needed______________

Does the medication need to be refrigerated? ☐ YES ☐ NO ______________

Condition for which the medication is being issued: ___________________________________________

Any adverse effect the medication can have or has had on your child: _______________________________

_____________________________________________________________________________________

The medication is to be continued through the following date: ____________________________________

Name and phone number of prescribing physician: ____________________________________________

- **ALL medication MUST be in the original container.**
- Please label medication with your child's name.
- Please include a medicine dispenser with your child's medication.
- Please pick up medication if TCC is no longer administering medicine.

___________________________________________ _________________________

Parent/Guardian Signature Date

*********************************************************************************

TCC Office Use Only:

| Date | Time (actual) | Staff Administering Medicine/Notes |
| --- | --- | --- |
| __________ | ____________ | __________________________________________________ |
| __________ | ____________ | __________________________________________________ |
| __________ | ____________ | __________________________________________________ |