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**MEDICATION RELEASE AND CHART**

**Child’s Full Name** **Last**  **First** **Middle**

**Name of Center**

**Address of Center**

**City**  **Zip Code**

**Telephone Number** ( )

**Parent’s Instruction**:

Children receiving medication from a staff member at the center must have:

1. Original prescription bottle with drug name, date, child’s name, prescribing physician’s name, dosage, times and dates to be given.
2. This form completed by the parent and physician for any prescription medication and over-the-counter medication prescribed by a physician

Physician’s Release (required for any medication to be given)

Diagnosis Medication Dosage

Times to be given Dates to be given

Date Signature, MD

Our medication procedure is primarily established to accommodate the administration of medication commonly prescribed by physicians for short-term illness. Staff on an individual basis will review each situation. We reserve the right to refuse responsibility for medication at the initial request of the parent/guardian or at any time during the period of administration after notification of the parent/guardian.

I hereby instruct and giver permission to the staff of to Administer the above named mediation to my child.

From to .

(Child’s Name) (Date) (Date)

I understand that this service is an accommodation for me and I will not hold the staff, administrative personnel, of Campus Kids Connection, Inc. liable for either the proper administration of doses, times, dates, or for any adverse effect of the medication given.

**Date** **Signature of Parent/Guardian**

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| --- | --- | --- | --- |
| **Date** | **Time** | **Dose/Medication** | **Signature or person**  **Administering medicine** |
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