KINGWOOD CHRISTIAN CHILD DEVELOPMENT CENTER

A Division of Kingwood Christian School

A Ministry of Kingwood Assembly of God

MEDICATION AUTHORIZATION

Child's Name: Teacher's Name: Date of Birth: Weight:

Prescription # or NDC#: Days given over weekend: Time of Last Dose:

Medication: Dosage: Route: Time(s) to be given:

Storage Instructions: Start Date: End Date:

Reason for Medication:

I hereby give permission for my child ( ) to be issued the above medication.

(Child's Name)

This medication is being given at my request.

Parent's Signature: Date:

***** KCCDC Use Below Only**

	TIME	SIGNATURE	TIME	SIGNATURE	TIME	SIGNATURE
MONDAY						
TUESDAY						
WEDNESDAY						
THURSDAY						
FRIDAY						

School Year

July 1, 2010-June 30, 2011

NURSE APPROVAL TO FILE AS OF: (Date) (Nurse Initial)

In order to promote communication, a parent's written permission is required every week (Monday-Friday) at KCCDC. Thank you for your assistance.

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