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|  | **Medication Permission Form****for Illness and Allergies (FFN)** |

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| **CHILD’S INFORMATION** |
| Name of child | Date of birth | Today’s date |
| Name of medicine | Dose |
| Time(s) to give medicine |
| Date to start medicine | Date to stop medicine |
| Known side effects to medicine |
| Training for special medical procedures that the provider may have to administer to the child; provided by child’s parent.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_Provider Signature Date Parent or Guardian Signature Date |
| How is this medicine given?[ ]  By mouth[ ]  In the ear [ ]  In the eye [ ]  Nebulizer[ ]  On the skin[ ]  Other  | Child allergies |
| **PRESCRIBER’S INFORMATION** |
| Prescribing health professional’s name |
| **PERMISSION TO GIVE MEDICINE** |
| I hereby give permission for the provider to give the medication as prescribed above. |
| Parent or guardian name (Print) |
| Parent or guardian signature | Date |
| Phone number      | Alternate phone number      | Alternate phone number      |