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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | |