Medication Release Form

Please Write Clearly

Name of Child: _____ Age: _____

Name of Medication: _____

Condition Being Treated: _____

Date(s) Medication is to be Given: _____

Time(s) Medication is to be Given: _____

Dosage / Amount to be Given: _____

Method of Administration (for example, orally, topically, nasally, etc.): _____

Possible Side Effects or Interactions with Other Drugs: _____

_____

I hereby give my permission for the provider to administer this medication according to the instructions above. I agree that the provider will not be held liable for any illness or injury resulting from the administration of this medication, and will not be held responsible for the reimbursement of any medical expenses resulting from such action.

_____ _____/_____/_____

Signature of Parent or Guardian Date

Verbal Authorization: Date & Time: _____ Provider's Signature _____

Parent's Signature _____

Medication Administration Record					
Date	**Time**	**Dosage**	**Administered By**	**Reactions**	**Administration Errors**
____/____/____					
____/____/____					
____/____/____					
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____/____/____					

This form is provided for technical assistance purposes only. Providers may use this form if they choose, but are **not** required to use this form.