Physician's Direction to Administer
NON PRESCRIPTION
Medication

BETHANY CHILD CARE CENTRE

Dear Doctor,
It is the policy of this Child Care facility to require physician's direction for use of non-prescription medication. Please complete a separate form for each medication required and include detailed directions for its use.

Child's Name _____ Birthdate _____
y/m/d

Name of Medication _____

Reason for Medication _____

List signs and symptoms or other indications _____

_____

Dosage _____ Route of Administration _____

How soon can this dose be repeated? _____mins/hrs.

How many times/day can this medication be given? _____

This documentation is valid for maximum one year or the following specified time period:

from _____ to _____
y/m/d y/m/d

Additional Comments _____

_____

_____

Physician's Name (please print)_____ Phone _____

Date _____ Physician's Signature __ _____
y/m/d

NOTE TO CAREGIVER: ***Each time the medication is given, it must be recorded on the Medication Record attached.***

(See reverse for Parent/Guardian Permission to administer Non-Prescription Medication)

Parent /Guardian Permission to Administer
NON PRESCIPTION
Medication

I hereby give my permission for the child care staff to administer the medication, indicated on reverse, according to the physician's order and instructions. I agree to complete a new permission form if there are any changes to the medication or instructions. I understand that the information supplied on this form will be considered valid for maximum one year from the date of signature.

Parent/Guardian Name: _____ Phone _____
(please print)

Date _____ Parent/Guardian Signature _____
y/m/d

(To be completed when unused medication/medication container returned to parent/guardian)

☐ Medication/container received from caregiver.

Date _____ Parent/Guardian Signature _____

(See reverse for Physician's Direction to Administer Non-Prescription Medication)