Updated January 2013

THE LINCROFT CENTER FOR CHILDREN
1475 West Front Street
Lincroft, NJ 07738
(732) 530-0643 Fax: (732) 530-0858

# PERMISSION TO GIVE ORAL OR TOPICAL MEDICATION

Child's Name________________________________________________

Child's Date of Birth____________________Teacher________________________________

Prescription Name and Number ________________________________

Description of Medication (i.e., yellow capsules, pink liquid)

________________________________________________

Reason for Medication ________________________________________________

Time of Day to be Given ______________________Amount to be Taken ___________________

Possible Side Effects ________________________________________________

______________________ ________________
Signature of Parent Date

**NOTE: All medications to be given by The Lincroft Center for Children's staff must be in the original bottle with pharmacy label showing name of medication, date of prescription, physician's name, child's name and dosage.**
**Parent must supply a teaspoon for administering correct dosage.**

**THE LINCROFT CENTER FOR CHILDREN IS NOT RESPONSIBLE FOR ANY ADVERSE REACTIONS TO MEDICATIONS.**

## Medication Given

| | Date | Time | By | | Date | Time | By |
|---|---|---|---|---|---|---|---|
| 1. | | | | 7. | | | |
| 2. | | | | 8. | | | |
| 3. | | | | 9. | | | |
| 4. | | | | 10. | | | |
| 5. | | | | 11. | | | |
| 6. | | | | 12. | | | |