ANOKA COUNTY HUMAN SERVICES
PERMISSION TO ADMINISTER MEDICATION

I hereby give my permission to: ______________________________

(NAME OF CHILD CARE PROVIDER)

to administer medication to: ______________________________

(NAME OF CHILD)

NAME OF MEDICINE: ______________________________

REASON FOR TAKING MEDICINE: ______________________________

AMOUNT/DOSAGE: ______________________________

MEDICINE TO BE GIVEN FROM: ______________ to ______________

(DATE) (DATE)

PARENT/GUARDIAN SIGNATURE: ______________________________

DATE: ______________________________

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