WIU INFANT AND PRESCHOOL CENTER

AUTHORIZATION TO ADMINISTER MEDICATION

I HEREBY AUTHORIZE THE AUTHORIZATION OF THE FOLLOWING
MEDICATION TO MY CHILD BY:
WIU INFANT AND PRESCHOOL CENTER

Child’s Name:___________________________ Child’s Date of Birth:_______________________

Name of Medication:_____________________ Physician ordering medication:______________

Expiration Date:_________________________ Dose:___________________________________

# of Times to be given during the day:_______ Times of the day to be given:________________

MEDICATION LOG

Date	Time	Name of Medication/Dosage	Person Administering