Washington State Department of
Early Learning

Medication Permission Form

CHILD'S INFORMATION		
NAME OF CHILD	DATE OF BIRTH	TODAY'S DATE
NAME OF MEDICINE	DOSE	
TIME(S) TO GIVE MEDICINE		
DATE TO START MEDICINE	DATE TO STOP MEDICINE	
KNOWN SIDE EFFECTS TO MEDICINE		
ADDITIONAL INSTRUCTIONS		
HOW IS THIS MEDICINE GIVEN? (CIRLCE ONE) ☐ BY MOUTH ☐ IN THE EAR ☐ IN THE EYE ☐ NEBULIZER ☐ ON THE SKIN ☐ OTHER	CHILD ALLERGIES	
PRESCRIBER'S INFORMATION		
PRESCRIBING HEALTH PROFESSIONAL'S NAME		
PERMISSION TO GIVE MEDICINE		
I hereby give permission for the licensee to give the medication as prescribed above.		
PARENT OR GUARDIAN NAME (PRINT)		
PARENT OR GUARDIAN SIGNATURE	DATE	
ADDRESS		
HOME PHONE NUMBER ( ) -	CELL PHONE NUMBER ( ) -	ALTERNATIVE PHONE NUMBER ( ) -