Enso Movement | Guest Services

Medication Administration Form

Child's Name:		Permission Start Date:
Date of Birth:	Age:	Permission End Date:
Child has allergy to:		
	Child may carry medicine	Y / N
	Child may give him/herself medicine	Y / N

Medication Name:	Medication Expiration Date:
Dosage / How much to give:	
Route / How to administer:	
Give medication at these specific dates and times:	
Additional Notes:	

I give authorization to give medicine and to call the prescribing health care professional or pharmacy if needed.

_____ _____

Parent/Guardian Authorization Signature **Date**

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Medication Administration Form - Emergency Info

Child's Name:
Medication:

Doctor's Name:	Phone:
Pharmacy:	Phone:
Parent/Guardian Name:	Phone:
Parent/Guardian Name:	Phone:
Other Emergency Contact:	Phone:

Additional Instructions:

Medication Administration Record

The person who gives the child the medicine completes this Medication Administration Record. Copy this page when you need more lines to record medication administration. Attach page to the Medication Administration Permission.

If an error occurs and the child requires medical attention, call 9-1-1 and/or Poison Control (800-222-1222) immediately

Child's Name:			
Medication:			
Date	Time	Dosage	Signature