AUTHORIZATION TO DISPENSE MEDICATION

I hereby authorize Mrs. Poppins Childcare (Courtney Beyer and staff) to administer the following prescription(s) and/or over-the-counter medication(s) to:

_____ _____

Name of Child Date of Birth

Name of Medication:	Dosage:	Time(s) of Administration:	Prescribing Physician (When applicable):

MEDICATION MUST BE IN ITS ORIGINAL CONTAINER WITH THE CHILD'S NAME ON IT

_____ _____ _____

Name of Parent or Guardian (Please Print) Signature of Parent or Guardian Date

Witness/Owner _____ _____

If there are any changes to the prescription(s)/medication(s), a new authorization form must be filled out before I can begin to administer medications again. All medications administered will be kept on file with your child's records.