Garden City Childrens Center

323 Elliott Street, Beverly, Ma 01915
978-927-9898

Medication Administration Permission Form

______________________________ ______________________
Child's name **D.O.B.**

I give permission for my child to receive the following over the counter medications: (I understand it is my responsibility to supply Garden City Childrens Center with medication)

Over the counter medications:

Acetaminophen	dose_________	frequency_________________
Ibuprofen	dose_________	frequency_________________
Benedryl	dose_________	frequency_________________
Cough and cold	dose_________	frequency_________________
_____________	dose_________	frequency_________________

Consent for staff administration of medications: ___Yes ____No

This form must be signed by the child's pediatrician and parent before any over the counter medications can be administered. This form will be valid for one year from the date signed by the pediatrician/Physician. All medications must be sent in their original bottles and given according to directions / guidelines on the bottle unless otherwise advised by the child's pediatrician/Physician.

____________________________ __________________
Physician signature **date**

___________________________ _________________
Parents signature **date**