Creative Imaginations Medication Release

I, ___________________________ give permission for Creative Imaginations staff to administer the following medication to my child,___________________________. I agree that when medication is given according to instructions, I will not hold Creative Imaginations or its staff liable for any reactions or complications that may follow as a result of my child receiving this medication. Medication must be in the original container, with the child's name and expiration date clearly visible.

Signature of Parent: ____

To be filled out completely by parent or child's physician:

Name of Medicine: ____ Strength:_________________________

Reason for Needing Medicine: ____

Physician:____ Phone Number:____________________________

Date Prescription was filled:_________ Expiration Date:________ Date to start:_________ Date to finish:_________

(*please note that medication will not be administered for more than 10 consecutive days).*

Times to be administered: _________ (am/pm) __________ (am/pm) __________ (am/pm)

Amount to be administered per dose: __________________________________ Child's Age:_____ Child's Weight:_____

(please make sure dosage and unit of measure are accurate).

Medication should be stored:____

My child has had this medicine before: Yes / No

My child had a reaction to this medicine: Yes / No

If yes, please give details of reaction:____

If a reaction does occur, who should we call first?____

Please note: If a child experiences difficulty breathing, we will first call 911 and then the parents or emergency contacts.

Office Use Only: (to be kept in child's file)

Medicine is in original containers: Yes / No

Bottle Labeled with child's name: Yes / No

Expiration Date Checked: Yes / No   Checked By:____

DATE	DOSAGE	TIME	SIGNATURE	COMMENTS