ANNA'S BANANAS
DAYCARE & PRESCHOOL

Medication Permission Form
FROM YOUR PHYSICIAN

Today's Date: ___/___/___
Child's First and Last Name:_____

I have prescribed the following medications for this child and request that Anna's Bananas Daycare and Preschool administer dosages which are required while this child is at daycare.

Name of Medication:_____

Reason for the Medication:_____

Dosage of Medication:_____

Route of Medication:_____

Dates Medication is to be Administered: From:_____ To:_____

(A date range is REQUIRED and cannot exceed a two week time period for this medication. If needing longer than two weeks, Anna's Bananas will require a new Medication Permission form OR an ICCP-Individualized Child Care Plan before the two week time period is complete)

Time Medication is to be Administered:_____AM or PM (please circle)

Prescribing Physician's Name (Please Print)_____

Prescribing Physician's Signature:_____ Date:___/____/___

Prescribing Physician's Phone Number:__(_____)_____-_____

Anna's Bananas Daycare and Preschool Center has my permission to administer the aforementioned medication to my child as prescribed by his or her physician.

/ /

Parent/Legal Guardian Signature Date