

Christopher Robin's Playhouse & Childcare Centre Child Form for STAFF-Administered Medical/Herbal Medication

First name(s) of child: _____ Last name of child: _____

Medication/Herbal Remedy: _____

Amount to be given: _____

Start date: _____ End date: _____

Times child needs to administer: _____

Special instructions/additional comments: _____

I, _____ parent/guardian of the named child above, give permission for a staff of CRPACC to administer the above medication to my child. I understand that all medication/herbal remedies must be in the original container and dosage may not exceed the amounts given on the label.

Signature of Parent or Guardian

Date Signed

Date:	Medication:	Dosage:	Time:	Witnessed by:

PLEASE NOTE ALL MEDICATION SHEETS EXPIRE AFTER 1 YEAR AND MUST BE UP-DATED EVERY SIX MONTHS

Christopher Robin's Playhouse & Childcare Centre

Child Form for SELF-Administered Medical/Herbal Medication

First name(s) of child: _____ Last name of child: _____

Medication/Herbal Remedy: _____

Amount to be given: _____

Start date: _____ End date: _____

Times child needs to administer: _____

Special instructions/additional comments: _____

I, _____ parent/guardian of the named child above, give permission for my child self-administer _____, I understand that the times administered during Program hours will still be documented recording that staff have witness my child administering the specific medication at the times required. I understand that all medication/herbal remedies must be in the original container and dosage may not exceed the amounts given on the label. If my child needs help, I give permission for the staff of CRPACC to assist my child if necessary.

Signature of Parent or Guardian

Date Signed

Date:	Medication:	Dosage:	Time:	Witnessed by: