# WIU INFANT AND PRESCHOOL CENTER
## AUTHORIZATION TO ADMINISTER MEDICATION

*I HEREBY AUTHORIZE THE AUTHORIZATION OF THE FOLLOWING MEDICATION TO MY CHILD BY: WIU INFANT AND PRESCHOOL CENTER*

**Child's Name:**______________________________ **Child's Date of Birth:**_________________________

**Name of Medication:**_______________________ **Physician ordering medication:**_______________

**Expiration Date:**____________________________ **Dose:**_______________________________________

**# of Times to be given during the day:**_______ **Times of the day to be given:**_________________

**Date and Time of last dose:**__________________________________________________________

**Length of Time medication is to be given:**_____________________________________________

**MM/DD/YY to MM/DD/YY**

**Prescription Number:**___________________________

_________________________________________________ ________________________________________

**Parent/Guardian Signature** **Date Signed**

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**Director's Signature**

# MEDICATION LOG

| Date | Time | Name of Medication/Dosage | Person Administering |
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