Scarborough Community Services
Child Care Program
Main Office 207-730-4150 | **Child Care Office** 207-730-4170
Fax 207-730-4165 | comserv@scarboroughmaine.org

PERMISSION TO ADMINISTER MEDICATION

Child's Name: _____

Name of Medication: _____

Prescribing Doctor: _____

Type of Medication: ORAL TOPICAL OTHER (please specify)

Specific area of application if topical: _____

Dosage: _____ Times(s) to be administered: _____

Possible Side Effects: _____

Start from: _____ to _____
Date *Date*

The following MUST be provided with this form

1) ____ Pharmacy Prescription Bottle with the child's name, name of medication, date filled, expiration date, and prescribing Doctor's name.

2) ____ Parent/Guardian Signature Below

I hereby request that the Community Services Staff administer the above medication to my child. I am aware that this medication will be administered by trained non-medical Community Services personnel.

_____ _____
Parent/Guardian Signature *Date*