

**Scarborough Community Services**  
**Program Medication Permission**

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_ Time(s) of Administration: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Side Effects: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Parent Signature: \_\_\_\_\_

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*Staff Use Only*

\_\_\_\_\_

SCS Administrator

\_\_\_\_\_

Date