

Release of Medication
Chicago Latvian Childcare and Preschool

Section I: Physician's Instructions

_____ (name of child) is under my care and should receive the following medication and dosage:

| Name of medication | Dosage | Specific instructions | Possible side effects | Expiration date |
|--------------------|--------|-----------------------|-----------------------|-----------------|
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| Signature of Physician: | Date: | Telephone Number: () |
|-------------------------|-------|-----------------------------|

Note: If medication or vitamin is a prescription from pharmacy, physician's instructions and signature will not be required. Instead of having the above section completed, the parent completes the chart below:

| | |
|-----------------|-----------------------------|
| Rx Number: | Pharmacy: |
| Street Address: | Telephone Number: () |

* Section I does not need to be completed for certain non-prescription items: fever-reducing medicines that do not contain aspirin; cough or cold medications that do not contain codeine; and topical ointments, creams or lotions.

Section II: Parent/Guardian Request for Administration of Medicine, Vitamin, Food Supplement or Modified Diet

I hereby request and give permission to the staff of CLCP to administer the following medication, vitamin, or special diet to my child:

| Name of medication | Dosage | Specific instructions | Possible side effects | Expiration date |
|--------------------|--------|-----------------------|-----------------------|-----------------|
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|----------------------|-------|
| Signature of Parent: | Date: |
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Section III: Record of Medication given by CLCP Staff

Name of Child _____

Name of Medication: _____

| Date given | Amount of dosage | Time Administered | Staff signature |
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Name of Medication: _____

| Date given | Amount of dosage | Time Administered | Staff signature |
|------------|------------------|-------------------|-----------------|
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Name of Medication: _____

| Date given | Amount of dosage | Time Administered | Staff signature |
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