# PERMISSION TO ADMINISTER SHORT COURSE OF MEDICINE/TREATMENT

Child's Name: _____ Date permission given by parent: _____

Start date: _____ End date: _____

Parent's signature: _____ Practitioner's signature: _____

| Name of medication or description of treatment | Required dose/treatment | Time to administer | Practitioner's initials, date & time when administered | Parent to initial after confirmation of administration |
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