

Pediatric Associates of Mt. Carmel, Inc

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Established 1972
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MEDICATION PERMISSION FORM

I/we are the parents of : _____

Address : _____

Phone: _____ School/Day Care: _____

I Authorize _____ to administer the following drugs to my
School/Day Care

son/daughter. I will deliver the medication to school/daycare and submit to school/day care personnel a
written statement signed by physician if any of the information provided by the physician changes.

Parent's Signature

It is necessary for the aforementioned child to take medication during school/daycare hours. I will notify
the school/day care if the medication, the dosage or the procedure is to be changed or eliminated.

Name of Medication: _____ Dosage : _____

Directions: _____

Beginning Date : _____ Ending Date : _____

Possible Adverse Reaction(s): _____

Any Special Instructions: _____

Physician Signature: _____ Date; _____

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2055 Hospital Drive
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4371 Ferguson Drive
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