

JUDAH'S CUB CARE

AUTHORIZATION TO ADMINISTER MEDICATION

Date _____ Child's Name _____

_____ has my permission to administer the following
prescription medications to my child.

Dosage instructions _____

_____ has my permission to administer the following
over-the-counter medications to my child.

Dosage instructions _____

_____ has my permission to apply the following
creams, lotions or ointments on my child.

Application instructions _____

_____ has my permission to apply the following
sunscreen or sun block on my child.

Application instructions _____

Signature of Parent or Guardian

Date

Signature of Parent or Guardian

Date