

Permission for Medical Condition Treatment

Parent or Guardian signature indicates permission for child care provider to follow these instructions:

(Parent Signature)

TO: Facility name _____ Phone: _____
Address: _____ Fax: _____

Child's name: _____ Date of Birth: _____

Address: _____

Medical condition(s) of concern: _____

Signs and/or symptom(s) to watch for: _____

Medications: _____ Dose: _____

How given: _____ When given? _____

Possible side effects: _____

Temporary program adaptations: _____

When to call parent/health provider regarding symptoms or failure to respond to treatment:

When to consider that the condition requires urgent care or reassessment:

FROM: Health care provider: _____ Phone: _____
Address: _____
Date of exam: _____