



PARENT MEDICATION CONSENT FORM

I, (Parent or Guardian Name) _____,

authorize Footsteps Child Care to administer to my minor child (Child's Name),

the following medication or medications:

NAME OF MEDICATION: _____

DATE (S): _____

DOSAGE: _____

TIME OR TIMES: _____ AM PM _____ AM PM

METHOD OF USE OR LOCATION ON BODY:

NAME OF MEDICATION: _____

DATE (S): _____

DOSAGE: _____

TIME OR TIMES: _____ AM PM _____ AM PM

METHOD OF USE OR LOCATION ON BODY:

NAME OF MEDICATION: _____

DATE (S): _____

DOSAGE: _____

TIME OR TIMES: _____ AM PM _____ AM PM

METHOD OF USE OR LOCATION ON BODY:



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