

THE CHILDREN'S CABINET
CAREGIVER'S SUPPORT NETWORK
Mildly Ill Child Care Program

RELEASE TO ADMINISTER NON-PRESCRIPTION MEDICATION

Child's Name: _____ Birth date: _____
Current Weight: _____
Fever Reliever*: _____ dosage: _____
(Type/Brand) frequency: _____
Decongestant*: _____ dosage: _____
Type/Brand frequency: _____
Cough Suppressant*: _____ dosage: _____
Frequency: _____
Anti-emetic*: _____ dosage: _____
Frequency: _____
Anti-diarrhea*: _____ dosage: _____
Frequency: _____
Other*: _____ dosage: _____
Frequency: _____

Please include any alternative treatments such as homeopathic or herbal compounds.

Diaper Ointment: _____
(Type/Brand and when to apply)
Other Ointment or salve: _____
(Type/Brand and when to apply)

Other Pertinent information: _____

This Release to Administer Non-prescription Medication remains valid through _____.
Date

Physician's Signature: _____ Date: _____

Address: _____ Telephone: _____

Parent/Guardian Signature: _____ Date: _____

These medications, specifically named, must be available at time of care. No alternatives or substitute brands please.