Children's Center

1919 W. Taylor St. M/C 525
Chicago, IL 60612
uicchildcenter@uic.edu

AUTHORIZATION TO ADMINISTER PRESCRIBED MEDICATION

The staff of UIC Children's center is requested and authorized to administer medication prescribed for my child a stated below:

Child's Name_____

Medical Condition_____

Medication Name_____ Prescription #_____

Prescribed by_____

Dosage/amount_____

Medication to be given: ____Orally ____Topically ____Other (Describe)

To be given at (time)_____

To begin on (date)_____ To continue until (date)_____

Other instructions_____

_____

_____

_____

I GIVE PERMISSION FOR THIS INFORMATION TO BE POSTED PUBLICLY

_____ _____

Date Parent(s) Signature

I UNDERSTAND THE MEDICATION DIRECTIONS AS DESCRIBED ABOVE

_____ _____

Date Teacher(s) Signature