Washington State Department of CHILDREN, YOUTH & FAMILIES

Medication Permission Form for Illness and Allergies (FFN)

CHILD'S INFORMATION		
Name of child	Date of birth	Today's date
Name of medicine	Dose	
Time(s) to give medicine ***(May not say as needed, descripe symptoms and times, list how often)***		
Date to start medicine	Date to stop medicine	
Known side effects to medicine		
Training for special medical procedures that the provider may have to administer to the child; provided by child's parent. _____ _____ _____ _____ Provider Signature Date Parent or Guardian Signature Date		
How is this medicine given? ☐ By mouth ☐ In the ear ☐ In the eye ☐ Nebulizer ☐ On the skin ☐ Other	Child allergies	

PRESCRIBER'S INFORMATION
Prescribing health professional's name

PERMISSION TO GIVE MEDICINE		
I hereby give permission for the provider to give the medication as prescribed above.		
Parent or guardian name (Print)		
Parent or guardian signature	Date	
Phone number	Alternate phone number	Alternate phone number