WIU INFANT AND PRESCHOOL CENTER
AUTHORIZATION TO ADMINISTER MEDICATION

I HEREBY AUTHORIZE THE AUTHORIZATION OF THE FOLLOWING MEDICATION TO MY CHILD BY:
WIU INFANT AND PRESCHOOL CENTER

Child's Name:_____ Child's Date of Birth:_____

Name of Medication:_____ Physician ordering medication:_____

Expiration Date:_____ Dose:_____

# of Times to be given during the day:_____ Times of the day to be given:_____

MEDICATION LOG

Date	Time	Name of Medication/Dosage	Person Administering