PAIN RELIEVER PERMISSION FORM

Child's Name: _____

Date: _____

Dear Physician:

In order to comply with Colorado State laws, the child care provider is required to receive written authorization from the physician to allow the following over the counter medication to be administered. This form is valid for one year and does not cover prescription medication.

Child's Pain Reliever **Brand:** _____

Dosage: _____

Note: Infants may need to have this form completed more often due to rapid growth and change of dosage. We will only administer the does indicated on this form.

_____

Physician's Signature

_____

Address

_____

Phone Date

These medications will only be administered for occasional use with parental permission. If any condition persists the parent or guardian will be requested to have the child seen by a physician.