Medication Release Form

Child's Name: _____ Date: _____

Medication: _____ Dosage: _____

Medication will be given at the same time each day, so please state the specific time.
Medication cannot be given "as needed"

Time(s) to be administered: _____

Method: _____ Special Instructions: _____

Date to begin: _____ Date to end: _____

I authorize all members of the Maryvale administration team to give my child the above listed medication. Prescription medication can only be given as noted on the prescription, non-prescription medications will be given in accordance with the product label.

Parent Signature: _____

To be Completed by Maryvale Associate providing the medication

Date	Time Given	Dosage	Method	Signature	Adverse Reactions