

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: _____

