

WIU INFANT AND PRESCHOOL CENTER  
AUTHORIZATION TO ADMINISTER MEDICATION

I HEREBY AUTHORIZE THE ADMINISTRATION 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: \_\_\_\_\_

