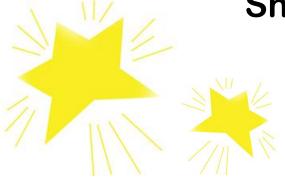
Shining Stars Childcare, LLC





Med	lical	l Aut	∵h∩r	ำวล:	tıon

	give permission to Shining Stars Childcare, LLC to give my child the below described
	Shining Stars Childcare, LLC agrees to administer
	prescribed by a licensed health care provider. I also give permission for my child's
•	formation about the administration of the following medication. It is the parent's
,	dication. The parent agrees to pick up expired or unused medication for proper
disposal.	
Prescribed Medications: must be	e in the original container labeled with the child's name, name of medication to be
given, dosage, date medication	is to be stopped.
Over-the-counter Medications:	must be in the original container labeled with the child's name.
Parent/Guardian	 Date
Health care provider authorizat	ion to administer medication at Shining Stars Childcare, LLC
·	ion to administer medication at Shining Stars Childcare, LLC Birthdate
Child's Name	Birthdate
Child's Name	
Child's Name	Birthdate
Child's Name Medication To be §	Birthdate Dosage iven at the following times
Child's Name Medication To be a	Birthdate Dosage
Child's Name To be a Special Instructions	BirthdateDosage iven at the following times
Child's Name To be a Special Instructions	BirthdateDosage iven at the following times
Child's Name To be a Special Instructions Purpose of medication	Birthdate
Child's Name To be a Special Instructions Purpose of medication Medication start date	Birthdate
Child's Name To be a Special Instructions Purpose of medication Medication start date	Birthdate