

Fulton County Family Partnership
Dosage and Permission Slip
THIS FORM MUST BE UPDATED EVERY 6 MONTHS

Childs Name: _____

Age: _____ Weight : _____

Doctor's name and address: _____

Doctors phone number: _____

Acetaminophen (infant)

Ibuprofen (infant)

Children's Elixir

Suspension

Date: _____ Physician Signature: _____

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I give permission for the staff at The Fulton County Center for Families to administer the above medication and dosage to my child when needed.

_____ Call me first at all times
_____ Only if fever is above _____ degrees
_____ Other _____

Date: _____ Signature: _____

Parents must supply appropriate medications