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