

REQUEST FOR ADMINISTRATION OF MEDICATION

Name of Facility: _____ Date: _____

Child's Name: _____ Birthdate: ____/____/____

Medication to be prescribed by a physician and/or non prescription medication provided by the parent – in the original container labelled with the child's name/dosage/time.

Parent or Guardian: _____ Phone #'s: _____

Physician's Name: _____ Phone: _____

Name of Medication: _____ Prescription Number: _____
(located on vial or bottle for prescription medications)

Medication is in the form of: Pills Drops Cream Other _____

Dosage: _____ Time: _____

Reason for Medication: _____

Additional Comments: (possible reactions, consequences of missing medication, medication to be given with, etc.)

I hereby give permission for the staff to administer the above named medication to my child according to the orders and instructions I have provided. I agree to notify the staff and complete a new request form if there are any changes to the medication or instructions.

Signature of Parent/Guardian _____ Date: _____

RECORD OF MEDICATION ADMINISTERED

Date Commenced: _____ Date Stopped: _____

DATE	TIME	DOSAGE	COMMENTS	STAFF SIGNATURE

*Please use a separate form for each medication or refill.
*Please ensure unused medication is returned to the parent/guardian.