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.