

MEDICATION ADMINISTRATION FORM

Child's Name: \_\_\_\_\_ Medication: \_\_\_\_\_

Prescription    Non-Prescription   Refrigeration Required    YES    NO

If Prescription, Prescriber's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Dosage Amount: \_\_\_\_\_ Route: \_\_\_\_\_ Time to Administer: \_\_\_\_\_ a.m. \_\_\_\_\_ p.m.

Expiration date: \_\_\_\_\_ Lot Number: \_\_\_\_\_

Special instructions i.e., symptoms signaling need for administration, medication indications, reasons to hold medication, contraindications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I give permission to administer medication to my child as stated above.

*Parent Signature* \_\_\_\_\_ *Date* \_\_\_\_\_

Prescription and non-prescription medication shall be administered to a child in care with a **daily written request** of the child's parent.

*Parent Signature and Date* \_\_\_\_\_ / \_\_\_\_\_ *Administration Date* \_\_\_\_\_

*Parent Signature and Date* \_\_\_\_\_ / \_\_\_\_\_ *Administration Date* \_\_\_\_\_

*Parent Signature and Date* \_\_\_\_\_ / \_\_\_\_\_ *Administration Date* \_\_\_\_\_

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*Parent Signature and Date* \_\_\_\_\_ / \_\_\_\_\_ *Administration Date* \_\_\_\_\_

