REQUEST FOR ADMINISTRATION OF MEDICATION

Name of F	acility:				Date:				
Child's Nar	me:				Birthdate:_		_/	/	
			physician ar ner labelled					orovided	l by
Parent or Guardian:				Phone #'s:					
Physician's Name:				Phone:					
Name of M	ledication: _			P	rescription N cated on vial o	lumbe r bottle	er: for prescr	iption med	 ications)
Medication	is in the fo	rm of: Pills [☐ Drops ☐	Cream 🗆] Other □				
Dosage: _				Time:					
Reason for	· Medicatior	n:							
to the orde form if ther	rs and instr e are any c	uctions I have hanges to the	ff to administe e provided. I a e medication c	agree to not or instruction	tify the staff ans.	and c	omplete	a new re	equest
			ORD OF MED						
Date Com	menced: _			Date Sto	opped:				
DATE	TIME	DOSAGE	C	OMMENTS		STA	AFF SIG	NATURE	
									_
	+								\dashv

^{*}Please use a separate form for each medication or refill.

^{*}Please ensure unused medication is returned to the parent/guardian.