Medication Administration Form

NAME OF CHILD ____

NAME OF MEDICATION ____

PRESCRIPTION NUMBER____

AMOUNT OF EACH DOSAGE ____

TIME OF DAY TO BE GIVEN ____

METHOD OF GIVING DOSAGE ____

DATE: FROM ________________________ TO ____________________________

POSSIBLE SIDE EFFECTS ____

REASON FOR MEDICATION ____

PERSON DESIGNATED TO ADMINISTER MEDICATION ___________________

NAME OF PARENT OR GUARDIAN ____________________________________

__________________________________ ______________________

PARENT OR GUARDIAN SIGNATURE DATE

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PHYSICIAN NAME

- **Over the counter and prescription medication must be in the original, labeled container.**

- **Provide a doctor's note for prescription medication.**

USE SEPARATE FORMS FOR EACH MEDICATION

USE SEPARATE FORMS FOR EACH CHILD