MEDICATION ADMINISTRATION FORM

Child's Name:		Medication:	
☐ Prescription	☐ Non-Prescription	Refrigeration Required ☐ YES	□ NO
If Prescription, P	rescriber's Name:	Telep	phone:
Dosage Amount:	Route:	Time to Administer:	a.m p.m
Expiration date: _	Lo	t Number:	
•	ns i.e., symptoms signa	aling need for administration, medic	cation indications, reasons to
			· · · · · · · · · · · · · · · · · · ·
I give permission	to administer medication	on to my child as stated above.	
ParentSignature ₋			Date
request of the chi		on shall be administered to a child ir	care with a daily written istration Date
Parent Signature a	nd Date	/Admin	istration Date
Parent Signature a	nd Date	/Adminis	stration Date
Parent Signature a	nd Date	/	istration Date
Parent Signature a	nd Date	/Admin	istration Date

FACILITY STAFF COMPLETE THIS SECTION (Staff initials and signature below)

Date Administered (mm/dd/yyyy)	Time Administrated (a.m. / p.m.)	Amount of Medication Administered	Route	Comments/Reactions	Staff Initials
(IIIII/dd/yyyy)	(а.п. / р.п.)	Administered			
Side effect noted	d and action taken ((include date and t	time)		
Staff Signature: _				Staff Initials:	
Staff Signature: _				Staff Initials:	
Staff Signature: _				Staff Initials:	
*This information	n is confidential and	d may not be share	ed or released	without parent's write	ten

^{*}This information is confidential and may not be shared or released without parent's written permission.