Request for Administration of Prescription and Non-Prescription Medication

SECTIONS I & II MUST BE COMPLETED

Request for Administration of Prescription and Non-Prescription Medication, Food Supplement, Fluoride Supplement or Modified Diet. All Medications (Prescription and over the counter) MUST have a prescription label attached.

Note: Please complete a separate form for each medication

To be completed by Parent(s) if staff will administer prescription medication
Section I: Parent Request for Administration of Medication or Supplement

I hereby request and give permission to the authorized staff member to administer the following medication to my child.

Name of Child:_____ Age of Child: _____

Name of Medication or Supplement to be administered: _____

Dosage:_____ Time(s) of Dosage: _____

Signature of Parent:_____ Date: _____

To be completed and signed by a Physician if staff will administer prescription medication
Section II: Physician's or Dentist's Instructions:

Name of Child: _____ is under my care and should receive

_____ (name of Medication or Supplement).

Dosage:_____

Specific instructions for administration: _____

_____

Possible side effects: _____

_____

Signature of: _____

Physician/Physician Assistant/Clinical Nurse Specialist/Certified Nurse or Dentist

PLEASE PRINT PHYSICIAN/DENTIST'S NAME:_____

Date:_____ Phone: _____

Section III: Medication or Supplement Log for:

_____

Child's Name

Date and Time of Dosage	Amount of Dosage	Signature of Authorized Staff
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		