Request for Administration of Medication Form

The following section must always be completed by the parent/guardian.

Check all that apply and complete all of the information.

☐ Prescription Medication ☐ Non-prescription Medication ☐ Food Supplement
☐ Topical Product of Lotion ☐ Refrigeration Required ☐ Modified Diet

Name of Child ______________________________ Date of Birth _______________ Weight ____________

Name of Medication _________________________ Exact Dosage __________________________________

To be administered at the following times: For the following period of time:

____ ____

☐ I understand that my child must receive one dose of medication before arriving at school (unless the medication is used for emergencies).

Signature of Parent/Guardian _______________________________________ Date _____________________

The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant if:

1. The medication contains codeine or aspirin.
2. A physician's instruction is needed for a nonprescription medication (e.g. child does not meet minimum age or weight requirements as listed on the label instructions).
3. It is a sample medication without a prescription label.
4. The nonprescription medication is to be given longer than three consecutive days within a 14-day period.
5. The topical product or lotion and the physician's instructions exceed the manufacturer's instructions or use.

Name of Child _____________________________ Name of medication ____________________________

Dosage ____________________________________ Possible side effects to watch for are _________________

____

Expiration Date (May not exceed twelve months from the date of this request for medications or food supplements). _______________________________

Instructions ____

____

☐ This child is under my care and should receive the above medication as written.

Signature of Practitioner ____

Date ______________________________________ Phone Number ___________________________

This form is valid for no longer than twelve months and must be kept on file at the school for at least one year following the last administration of the medication or product. One form must be used for each medication.

The following section must be completed by the school for the child listed on page one of this form. All medication must be documented when administered.

Date	Time	Dosage	Signature of designated person administering medication

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.