MEDICATION FORM - *Only one medication per form*

CHILD'S NAME ON MEDICATION: _____
NAME OF MEDICATION ON LABEL: _____
DOSAGE ON LABEL: _____
DATES TO BE GIVEN: _____
TIMES TO BE GIVEN: _____ _____
ROUTE OF MEDICATION: ___oral ___ears ___eyes ___nose ___rectal ___topical
___inhalation Other: _____

REASON FOR MEDICATION: _____

SPECIAL INSTRUCTIONS FOR GIVING MEDICATION:

Refrigerate: YES NO

___ **PRESCRIPTION**

Dates on Medicine:
Fill date: _____
Exp. Date: _____

Pharmacy Sheets: (including possible side effects on file)
YES NO

CHILD'S WEIGHT

_____

___ **OVER-THE-COUNTER**

Expiration Date:

_____

Original Packaging:
YES NO

(IF DOSAGE IS NOT ON PACKAGING...)
Doctor's Authorization for AMOUNT:
YES NO

MONTH OF _____ **ADMINISTRATION OF MEDICATION:** *(INITIAL/TIME IN BOX AFTER GIVEN)*

MED/AMOUNT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
LAST DOSE:																														

I GIVE PERMISSION FOR COMMUNITY DAYCARE & PRESCHOOL CENTER TO GIVE MY CHILD, _____, HIS/HER MEDICATION AS DETAILED ABOVE AND TO CONTACT MY PHYSICIAN OR PHARMACY IF QUESTIONS ARISE OR A SITUATION OCCUR THAT INVOLVES MY CHILD OR THE MEDICATION.

PARENT NAME: PRINT_____ **SIGNATURE**_____ **DATE**_____