Parent / Guardian Request for the Administration of Medication

Child's Name_____ Classroom_____

Address_____ Teacher_____

_____ Grade Equivalent_____

Name of Medication to be given:_____

Dosage to be given:_____ Expiration date of Medication_____

Date the administration of medication should begin:_____

Date the administration of medication should end:_____

Times the Medication should be administered:_____

Specific Instructions:_____

_____

_____

_____

Possible side-effects to watch for:_____

Signature of Parent / Guardian
requesting administration:_____ Date:_____

Physician's Name:_____ Phone #_____

Physician's Signature:_____ Address: _____

_____

_____

Record of dosage(s) given to the above-named child:

Date & Time of Dosage	Amount of Dosage given	Signature of Administering Personnel

If more space is needed to record dosage information, please use the back of this sheet.