Administration of Prescription Medication at a Child Care Facility

N/A: ☐

Name of Child: _____ Date of Birth: _____

Name of Parent/Guardian: _____ Cell Phone: _____

Physician: _____ Phone #: _____

TO BE COMPLETED BY PHYSICIAN:

Name of Medication(s):

_____

Condition(s) which make Medication(s) necessary:

Dosage: Pills: _____ Drops: _____ Tsp: _____ Ounce: _____ Mls: _____

Start Date: _____ End Date: _____

Time: AM ☐ PM ☐ To be given with (food, water, juice): _____

Additional Comments: (possible reactions, consequences of missing medications, etc.)

Physician Name (printed): _____

Date: _____

Signed: _____