

MEDICATION ADMINISTRATION FORM AND DIRECTIONS

Date _____

Name of Child _____ Date of Birth _____

Address _____
Emergency Phone Number Hm _____ Work _____ Cell _____

Parents/Guardian Name(s) _____

Doctor's Name _____ Dr. Phone Number _____

I hereby request and authorize school personnel to administer his/her prescribed medication as directed by our doctor.

Signature _____

DOCTOR'S ORDERS

You are hereby directed to give to _____
Name of Child

His/her medication (name) _____

In the amount of _____ tablets/capsules at _____ am/pm daily.

Or as follows _____

Duration _____

Possible side effects _____

Doctor's signature _____

Doctor Phone Number _____