

GENERAL MEDICATION ADMINISTRATION

Office Use Only:
Name of Child:
Name of Medication:

To be completed by Parent/Guardian:	
Child's Name:	Is this medication already given at home?: Yes/No If YES,
Medication/Herbal Remedy:	When is this medication administered? _____
Expiration Date:	Have you used this medication before?: Yes/No If YES, Were there any negative reactions? Yes/No If YES, what were they? _____
Amount to be given/dosage:	When was the medication prescribed (excludes emergency medications):
Dates to be given: Start Date:	Is the child's name on the medication?: Yes/No
Finish Date:	Is medication in the original container?: Yes/No



Exact times to be given:	Name of Parent/Guardian:
Purpose for medication:	Signature:
	Date:
INITIALED BY DIRECTOR/DESIGNATE:	INITIALED BY LEAD TEACHER:
How to administer medication:	



