Medication Form

Child's Name ____

Dispensing Physician ____ Phone ________________________

Date(s) to administer medication: M________ T __________ W __________ TH ___________ F____________

Medication _____________________________Prescription _______________Over the Counter _____________

Possible Side Effects: ____

Dosage:____

Time to Administer: ______________________________As needed/In Case of Emergency _________________

Storage Directions:____

A copy of this form must be attached to each medication. All medication must be handed to a staff member

Parent Signature ____ Date ________________________

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