30 Albert St. Langton, ON N0E 1G0
519-875-2780 littlepeoples@bellnet.ca

ADMINISTRATION OF MEDICATIONS

NAME OF CHILD: _____

NAME OF MEDICATION: _____
(Exactly what is written on the medication label)

PRESCRIPTION NUMBER: _____

DOSE TO BE ADMINISTRATED: _____

TIME TO BE ADMINISTERED: _____
_____
_____
_____

DATE MEDICATION IS TO START: _____

DATE MEDICATION IS TO END: _____

STORAGE LOCATION: _____

SIGNS, SYMPTOMS AND WHEN TO ADMINISTER MEDICATION (explicit details):
_____
_____
_____
_____
_____
_____
_____

PARENTAL APPROVAL:
I request that and give permission for the staff to administer medication to my child, according to the procedures outlined and following the above detailed instructions.

Signature: _____

Date: _____

Staff Signature who assisted parent in completing form: _____

DATE	DOSAGE GIVEN	TIME GIVEN	STAFF INITIAL	SIGNS, SYMPTOMS, REASONS FOR ADMINISTERING

Staff initial when medication is finished: _____