Request for Administration of Medication

Child's Name: _____ DOB: _____

Type of Medication: ☐   Prescription   ☐   Non-Prescription

    *Name of Medication: _____   *Expiration Date: _____

    *Dosage to be given: _____

Times to be given: 1 _____   2 _____   3 _____

    Date to BEGIN Medication: _____   Date to END Medication: _____

Is child taking any other medicaitons at this time?   ☐   Yes   ☐   No

     If yes, please list medication(s): _____

I request that the staff of Jeanie's Child Development Center administer the above named medication as directed in the instructions listed above.

_____   _____

Parent/Guardian Signature   *Date*

MEDICATION LOG

Child's Name: _____

Medication	Dosage Given	Date	Time	Administered By	Parent's Initials

Must be on original container label