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 Little Blessings 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