REQUEST FOR THE ADMINISTRATION OF MEDICATION

Section I: Physician's Instructions

(Name of child) ____ is under care and should receive
(name of medicine, vitamin, or modified diet) ____
(dosage) ______________________________ , as follows . _______________________________________
Specific instructions for administration: ____
Possible side effects to watch for:____
Expiration date *(may not exceed six months from date of this request if prescribing medication or food supplement)*: ____/____/____

Signature of Physician	Date of Signature	Telephone Number ( )

Note: If medication or vitamin is a prescription from pharmacy, physician's instructions and signature will not be required. Instead of having the above section completed, the parent completes the chart below:

Rx Number	Pharmacy
Street Address	Telephone Number ( )

Section I does not need to be completed for certain non-prescription items: fever-reducing medicines that do not contain aspirin; cough or cold medications that do not contain codeine; and topical ointments, creams or lotions.

Section II: Parent/Guardian Request for Administration of Medicine, Vitamin, Food Supplement or Modified Diet

I hereby request and give permission to Debbie Andrews. to administer the following medication, vitamin, or special diet to my child:

Name of Child	Name of Medication	Dosage	Time(s) to be given

Signature of Parent	Date of Signature

Section III: Medication Given by Little Ones Child Development Home

(Name of child) ____ was given ______________________
(name of medicine, vitamin, or modified diet) _______________________________ *(dosage*, at the following time(s) _____________________ on the following date(s):

Date of Dosage	Amount of Dosage	Signature

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