Over the Counter Medication Administration Form

Medication must be in its original containter with the Child's name & dosage amount

Child's Name: _____ Date: _____

Child's Weight: _____

Medication: _____ Dosage Amount: _____

Reason for Medication: _____

Time to be Given: _____ (Dispensed once daily between 11:30-12:30)

Prescribing Physician: _____ Phone: _____

Physician Address: _____

Side Effects: _____

Physicians Signature: _____
(Only needed if dosage doesn't match your child's age / weight)

Storage Directions: _____

Time Given: _____ Staff Signature: _____

Parent's Signature: _____ Phone: _____

ALL MEDICATIONS MUST GO HOME AT END OF SCHOOL DAY

Parent's Initials at end of day: _____
(Showing medicine was taken home)

Medication will not be dispensed the following day if this form is not initialed at the end of the school day.