



Prescription Medication Administration Form

Medication must be in its original container 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: _____

Pharmacy Name: _____ Phone: _____

Pharmacy Address: _____

Side Effects: _____

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.**