Name of Medication or Supplement to be administered

Name of Child

## REQUEST FOR THE ADMINISTRATION OF PRESCRIPTION AND NON-PRESCRIPTION MEDICATION, FOOD SUPPLEMENT, FLOURIDE SUPPLEMENT, OR MODIFIED DIET

**NOTE:** A separate form must be completed for each medication.

## SECTION I: PARENT REQUEST FOR ADMINISTRATION OF MEDICATION OR SUPPLEMENT

Age of Child

I hereby request and give permission to the authorized staff member to administer the following medication to my child:

Dosage	Time(s) of Dosage	Signature of Parent/Guardian Date		
SECTION II: PHYSICIAN'S C	OR DENTIST'S INSTRUC	TIONS:		
Name of Child:			nd should receiv	
Dosage:Specific instructions for				
administration:				
Possible side effects:				
Signature of Physician/Physician	Assistant/Clinical Nurse Sp	ecialist/Certified Nurse or Dentist		
*	·			
Please Print Physician's/Dentist's Name		Date		
SECTION III: LOG OF MEDIO	CATION OR SUPPLEME	NT ADMINISTERED BY AUTHORIZED STAFF	MEMBER	
Date and Time of Dosage	Amount of Do	Signature of Authorized Staff Men	Signature of Authorized Staff Member	
Date and Time of Dosage	Amount of Do	osage Signature of Authorized Staff Men	nber	

Sample Form	Office of Early Learning and School Readine