MEDICATION REQUEST FORM

Child's Name: **Child's Class:**

THIS SECTION TO BE COMPLETED BY THE CHILD'S PARENT/GUARDIAN

Medical Condition	
Medication Name	
Allergies	
Date this medication started (if first time taking it)	
Dosage and timing	
Need to check time of previous dose (Non-prescription med)?	
To be kept in fridge?	
Dates required	
Parents signature	

Details of medication administered by staff:

Staff Name	Date	Time	Dosage	Notes