# MEDICATION REQUEST

Name of child:_____

Name of medication:_____

Dosage:_____

Time(s) to be given:_____

Date(s) to be given:_____

Reason for medication:_____

_____

Special Instructions:_____

_____

Does medication need to be refrigerated?_____yes_____no

*Prescription and non-prescription medication shall only be accepted in its original container. Prescription medications shall be labeled with the full pharmacy label. Non-prescription medication shall be clearly labeled with the child's first and last name.*

_____

*Parent/Guardian Signature* *Date*

For Center Use:

| DATE | TIME GIVEN | DOSE | GIVEN BY |
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