

HEALTHCARE PROFESSIONAL'S REQUEST FOR ADMINISTRATION OF
MEDICATION

Name of Child _____ Birthdate _____

In order to keep this child in optimum health it is necessary that medication be given at lunch time.

Name of Medication _____

Form of Medication to be given is circled below:

TABLET INJECTION CAPSULE LIQUID TOPICAL

Dosage (amount to be given) _____

The parent knows of this request and is in full agreement that this medication will be supplied as necessary.

Remarks _____

Physician's Signature

Telephone

Date

This is your permission to give medication to my child named above as requested by the physician.

Parent's Signature

Telephone

Date