PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION

Name of Child _____ Date _____

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 CAPSULE LIQUID

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

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

_____
Parent's Signature

_____
Telephone