

Medication Request

The first part of this form must be filled out and signed by the child's doctor. The second part must be filled out and signed by the child's parent/guardian. Both parts must be completed to enable the staff at Community Preschool of Cedar Grove to administer prescription medication to the child.

Part 1. Physician's Orders for Prescription Medication

Name of child: _____

Medication: _____

Condition for which it is prescribed: _____

Time of administration: _____

Dates of administration (check box and fill in the information)

☐ For _____ (number of) days, starting immediately.

☐ From _____ until _____ (insert dates).

☐ Administer medication as directed until it runs out.

Possible side effects: _____

Other notes: _____

Physician's signature: _____ Date: _____

Physician's address: _____

Physician's phone number: _____

Part 2. Parent/Guardian's Request to administer Prescription Medication

I, _____, parent/guardian of the above-named child, request that the staff at Community Preschool of Cedar Grove, administer the above medication to my child as prescribes above by the child's physician.

Parent or legal guardian's signature

Date of signature

Parent or legal guardian's signature

Date of signature