Weekly Medication Form

To be completed by the Parent: This form is required to be completed each and every week!

Child's Name:_____

Dates Authorized to Give Medication: _____(Not to exceed 1 week)

Name of Medication:_____

Dosage: _____Time to be given:_____

Method to give Medication/Special Instructions:_____
_____
_____
_____
_____
_____

Does Medication require refrigeration: yes / no

Was any medication given at home prior to coming to child care?_____

Parent/Guardian Authorization:_____**Date:**_____

To be completed by the Provider:

Name of Staff receiving medication from Parent:_____
Verification:
_____Medication in original container
_____Medication not out of date
_____Labeled with child's name

Date Given	Time Given	Amount Given	Given By	Side Effects/Reaction

Parent received information on administration of medication and unused medication returned to the Parent:

Parent Signature:_____**Date:**_____

(Note: must be a designated person to receive medication and a back up person if that staff member is out)