Medication Log

Child's Name_____

I give the Algonac Childcare Program Staff permission to administer the following *nonprescription* medication to my child according to the directions below. These directions are consistent with the directions on the medication label.

Name of Medication: _____
Times to Administer: _____
Dosage: _____
Beginning Date:_____ **Ending Date:**_____

_____ _____
Parent/Guardian Signature Date

DATE	TIME	AMOUNT	CAREGIVER'S SIGNATURE	WITNESS

PERMISSION FORM FOR MEDICATION

School: _____ Date received by school: _____

Student: _____ DOB or age: _____

Grade: _____ Teacher/Classroom: _____

To be completed by physician or authorized prescriber

Name of medication: _____

Reason for medication: (OPTIONAL) _____

Form of medication/treatment:

☐Tablet/capsule ☐Liquid ☐Inhaler ☐Injection ☐Nebulizer ☐Other_____

Instructions (Schedule and dose to be given at school):

Start: ☐Date form received Other dates: _____

Stop: ☐End of school year Other date/duration: _____

☐For episodic/emergency events only

Restrictions and/or important side effects: ☐None anticipated

Yes, Please describe: _____

Special storage requirements: ☐None ☐Refrigerate ☐Other:

This student is both capable and responsible for self-administering this medication:

☐No ☐ Yes (Supervised) ☐Yes (Unsupervised)

This student may carry this medication: ☐No ☐Yes

Please indicate if you have provided additional information:

☐On the backside of this form ☐As an attachment

Physician's Signature: _____ Date: _____

Physician's Name _____

Address _____ Phone _____

To be completed by parent/guardian

I request that (name of child) _____ receive the above medication at school according to standard school policy.

I request that (name of child) _____ be allowed to self-administer the above medication at school according to school policy.

Date: _____ Signature: _____ Relationship: _____