SCHOOLS OF QUALITY LEARNING

Medication Authorization / Record of Dispensation

Child's Full Name: _____ Classroom: _____

Name of Medication: _____ Prescription #: _____

Time Medication Is To Be Given: ___a.m.___ p.m. Dosage _____
WE ONLY ADMINISTER MEDICATIONS AT 10 AM AND AT 2 PM!!!!!!!

Dates: Start ____ End ____

_____ _____
Parent's Signature Date

For Center Use Only:

Date Given	Time Given	Dosage Given	Any Adverse Reaction	Administered By

ALL medicines, both prescription and nonprescription, must be in their original containers.

ALL nonprescription medicines require a note from the child's doctor with dosage amount.

Doctor's Signature_____

This school dispenses medication at _10am____ and _2pm____.

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If noticeable adverse reaction to medication occurs, parents will be notified and an incident report will be filled out.