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 _____

Dates: Start ____ End ____

_____ _____

Parent's Signature Date

For Center Use Only:

Date Given	Time Given	Dosage Given	Any Adverse Reaction	Administered By

Name of Medication: _____ Prescription #: _____

Time Medication Is To Be Given: _____a.m .____ p.m. Dosage: _____

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 non-prescription, must be in their original containers.

ALL non-prescription medicines require a note from the child's doctor.

This school dispenses medication at _____ and _____.

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