LA LUZ ECC REQUEST FOR ADMINISTRATION OF MEDICATIONS

NAME OF CHILD:_____ DOB:_____

CHECK TYPE OF MEDICATION: PRESCRIPTION_____ NON-PRESCRIPTION_____

NAME OF MEDICATION:_____

DOSAGE TO BE ADMINISTERED:_____

MEDICATION EXPIRATION DATE:_____

TIME MEDICATION IS TO BE ADMINISTERED: 1._____ 2._____ 3._____

TIME OF LAST DOSE GIVEN:_____

DATES MEDICATION IS TO BE ADMINISTERED: BEGIN:_____ END:_____

IS CHILD TAKING ANY OTHER MEDICATION AT THIS TIME: YES:_____ NO:_____

IF YES, NAME OF MEDICATION(S):_____

I REQUEST THE STAFF OF LA LUZ ECC TO ADMINISTER THE ABOVE MEDICATION ACCORDING TO THE PRESCRIBED INFORMATION.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

MEDICATION LOG

NAME OF MEDICATION	DOSAGE GIVEN	DATE	TIME	ADMINISTERED BY	PARENT INITIAL

***ALL MEDICATIONS MUST BE IN THEIR ORIGINAL CONTAINERS**