

**REQUEST FOR THE ADMINISTRATION OF PRESCRIPTION AND NON-PRESCRIPTION MEDICATION,  
FOOD SUPPLEMENT, FLOURIDE SUPPLEMENT, OR MODIFIED DIET**

**NOTE:** A separate form must be completed for each medication.

**SECTION I: PARENT REQUEST FOR ADMINISTRATION OF MEDICATION OR SUPPLEMENT**

I hereby request and give permission to the authorized staff member to administer the following medication to my child:

Name of Child		Age of Child	Name of Medication or Supplement to be administered	
Dosage	Time(s) of Dosage		Signature of Parent/Guardian	Date

**SECTION II: PHYSICIAN'S OR DENTIST'S INSTRUCTIONS:**

Name of Child: \_\_\_\_\_ is under my care and should receive  
 Name of Medication or supplement \_\_\_\_\_  
 Dosage: \_\_\_\_\_  
 Specific instructions for administration: \_\_\_\_\_  
 Possible side effects: \_\_\_\_\_

Signature of Physician/Physician Assistant/Clinical Nurse Specialist/Certified Nurse or Dentist	Phone #
Please Print Physician's/Dentist's Name	Date

**SECTION III: LOG OF MEDICATION OR SUPPLEMENT ADMINISTERED BY AUTHORIZED STAFF MEMBER**

Date and Time of Dosage	Amount of Dosage	Signature of Authorized Staff Member
Date and Time of Dosage	Amount of Dosage	Signature of Authorized Staff Member

