MED.001 MEDICATION REQUEST CHART

Child's Name:_____

For Parent/Guardian to Complete							For Staff Member to Complete				
Date	**Doctor's Name and Phone No.**	**Name of Medication**	**Dosage**	**Method of Administration**	**Time/s Required**	**Parent/ Guardian Signature**	**Date**	**Dosage**	**Time Given**	**Full Name & Signature Staff member giving medication**	**Witness Signature**