Scribbles
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REQUEST TO ADMINISTER MEDICATION

Child's Name _____ Date of Request _____

Medication _____

Dosage _____ Frequency _____

Method (by mouth, nose, ear) _____

Duration of Administration _____

Expiration Date _____

Requested by (Doctor's name and phone) _____

Special Instructions _____

Possible Side Effects to Watch For _____

_____ _____
Parent/Guardian Signature Date

Safety Check:

1. Child resistant container
2. Original prescription or manufacturer's label and physician's directions for use (phone or written)
3. Name of child on container
4. Current date on prescription/expiration label
5. Name and phone number of licensed health professional who ordered medication on container or on file