Babes on the Square
Preschool & Childcare Center

MEDICATION FORM

Child's Full Name: _____ Date of birth: _____

Known medication allergies: _____

Doctor's Name & Phone number: _____

Pharmacy Name & number: _____

Name of Medication: _____ Medication expiration date: _____

Dosage amount: _____ Time(s) to be given: _____ Route to be given: _____

Start Date: _____ End Date: _____

Reason for medication: _____ Special directions: _____

I, the parent or guardian, of the above child give permission for the above to be administered.

Signature: _____ Date: _____

Date (m/d/y)	**Time (**am/pm)	**Amount Given**	**Comments**	**Staff Signature**

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