1. PLEASE FILL OUT THIS FORM
2. DROP THIS FORM IN THE DAILY MEDICATION DROP BOX IMMEDIATELY
3. PLACE YOUR MEDICATION IN THE ZIPLOCK BAG AND FILL OUT THE LABEL
4. BRING THE MEDICATION TO THE KITCHEN AND PLACE IT IN THE MEDICATION BIN LOCATE ON THE TOP OF THE FRIDGE
5. MEDICATION WILL BE PLACED BACK IN THE MEDICATION BOX AT PICK UP TIME

I UNDERSTAND THAT THE MEDICATION WILL NOT BE GIVEN IF:

1. I AM NOT SET UP FOR REMIND APP
2. MEDICATION IS EXPIRED
3. MEDICATION IS NOT IN ITS ORIGINAL BOX (EXCLUDES OTC MEDICATIONS)
4. ANOTHER CHILDS NAME IS PRESCRIBED ON THE BOTTLE
5. DID NOT GET PROPER WRITTEN PERMISSION

I ______________________________ GIVE THE SCHOOL PERMISSION TO ADMINISTER THE FOLLOWING MEDICATION. I UNDERSTAND THAT THE SCHOOL IS NOT RESPONSIBLE FOR ANY MEDICATION GIVEN WHICH RESULTS IN A REACTION OR COMPLICATION AFTER MY CHILD RECIEVES THE DOSE THAT IS NOT DISCLOSED BELOW.

PARENT SIGNATURE ______________________________ DATE ______________

MUST HAVE *REMIND* CELL PHONE NUMBER (   )   -

CHILDS NAME ______________________________ **DOB** ______________________

NAME OF MEDICATION______________________________ **EXPIRATION DATE** ____/______

REASON FOR MEDICATION ______________________________

START DATE ______________________ ***END DATE*** ______________________ ***(GOOD FOR 1 WEEK ONLY)***

AMOUNT OF DOSE ______________________________ ***BY: MOUTH - NOSE – EYES – EAR - SKIN***

TIMES OF DOSES ____________/__________________/______________

ANY KNOWN REACTIONS CAUSED BY THIS MEDICATION? ______________________________

ADMINISTRATION ACKNOWLEDGMENT: ______________________________ ***DATE***_____ ***TIME*** ______

FOR THE ADMINISTERS ONLY: DATE_______NAME OF MEDICATION______________________ CHECKED THE 5 RIGHTS- Y/N

AMOUNT __________ TIME ____________ **STORED BACK IN ZIP BAG W/ PERM:** MEDICINE BIN / FRIDGE INITIAL________

FOR THE ADMINISTERS ONLY: DATE_______NAME OF MEDICATION______________________ CHECKED THE 5 RIGHTS- Y/N

AMOUNT __________ TIME ____________ **STORED BACK IN ZIP BAG W/ PERM:** MEDICINE BIN / FRIDGE INITIAL________

FOR THE ADMINISTERS ONLY: DATE_______NAME OF MEDICATION______________________ CHECKED THE 5 RIGHTS- Y/N

AMOUNT __________ TIME ____________ **STORED BACK IN ZIP BAG W/ PERM:** MEDICINE BIN / FRIDGE INITIAL________

FOR THE ADMINISTERS ONLY: DATE_______NAME OF MEDICATION______________________ CHECKED THE 5 RIGHTS- Y/N

AMOUNT __________ TIME ____________ **STORED BACK IN ZIP BAG W/ PERM:** MEDICINE BIN / FRIDGE INITIAL________

FOR THE ADMINISTERS ONLY: DATE_______NAME OF MEDICATION______________________ CHECKED THE 5 RIGHTS- Y/N

AMOUNT __________ TIME ____________ **STORED BACK IN ZIP BAG W/ PERM:** MEDICINE BIN / FRIDGE INITIAL________

****AT THE CONCLUSION OF MEDICATION DOSES GIVEN, PLEASE MAKE A COPY AND PLACE IT IN THE OFFICE****