PJA-Afterschool Department

MEDICATION FORM

(To be completed before medication can be administered)

Child's Name _____

Reason for administering medication _____

Child's Physician _____ **Phone** _____

Specific written instructions from Physician _____

_____

Name of medication to be administered _____

What time(s) should medication be administered _____

Dosage amount _____

How many times daily _____

Other important information _____

_____

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**

This form must be filled out each week AND when ANY information changes.

Parent's initials_____ Date _____	Parent's initials_____ Date _____	Parent's initials_____ Date _____
Parent's initials_____ Date _____	Parent's initials_____ Date _____	Parent's initials_____ Date _____
Parent's initials_____ Date _____	Parent's initials_____ Date _____	Parent's initials_____ Date _____
Parent's initials_____ Date _____	Parent's initials_____ Date _____	Parent's initials_____ Date _____
Parent's initials_____ Date _____	Parent's initials_____ Date _____	Parent's initials_____ Date _____
Parent's initials_____ Date _____	Parent's initials_____ Date _____	Parent's initials_____ Date _____

Medication Administered By

NAME	DATE	TIME	NAME	DATE	TIME