Fax to 219-365-9713
Email to

Medication Request Form

Name of Child: _____

Name of Medication: _____

Dosage: _____

Time(s) to be given: _____

Date(s) to be given: _____

Last time given: _____

Reason for Medication: _____

Special Instructions: _____

_____

Does medication need to be refrigerated?

☐ Yes

☐ No

Parent Signature: _____

** *Prescription medication must be brought to the center's pharmacy container. Label clearly with child's full name.*

For Center use only			
Date:	Time Given:	Dose:	Given By: