



MEDICATION

PARENT / CAREGIVER

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NAME OF CHILD

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I request a staff member to assume responsibility for the administration of medication as detailed below, to the abovenamed child.

I have provided the medication in its original container, which includes the child's name and the expiry date of medication.

In requesting this service, I undertake not to hold the staff responsible for any misadventure as a result of administering the medication as specified.

Doctor's Name: Type of Medication. Dose Time(s) Day Expiry Date

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Signed: **Date:**