

# Distribution of Medicine Form

Child's Name: \_\_\_\_\_

Grade: \_\_\_\_\_

Name of Medicine: \_\_\_\_\_

Date: \_\_\_\_\_

Provide instructions for the distribution of the prescribed medicine. Fill in the dates to administer, the time to administer, and the dosage. Check (instead of filling out the date and time) if medicine should be administered *as needed*:

Date to administer	Time to administer	Dosage	Time administered	Teacher's initials	Student's initials

Please provide any additional information if needed: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_

Date: \_\_\_\_\_