MEDICATION REQUEST/PARENTAL CONSENT FORM
Child Development Academy @ MU
Fax (304) 696-5805

PHYSICIAN'S ORDERS FOR MEDICATION ADMINISTRATION

Child's Name: _____

Name of Medication: _____

Dosage (amount to be given): _____
_____

Times of Administration: _____
_____

Route of Administration: _____
(By mouth, nose, ear, etc.)

Period of Treatment
Date: _____ to _____
NO LONGER THAN 6 MONTHS

Form of Medication To Be Given:
(circle below)
Tablet Pill Capsule Liquid
Inhalant Other (specify) _____

Refrigeration? _____ Yes _____ No

CANNOT BE AS NEEDED

Other specific instructions/conditions for administration: _____
_____
_____
_____

Remarks: (Expected reactions, side effects, possible adverse reactions, food/drug interactions)
_____
_____
_____
_____

_____
Physician's Signature Date Telephone #

PARENT'S PERMISSION

I hereby give my permission for my child (named above) to receive medication during center hours. I understand that the Child Development Academy at Marshall University undertakes no responsibility for the administration of medication. This medication has been prescribed by a licensed health professional. I hereby release Child Development Academy at Marshall University and its agents and employees from any liability that may result from my child taking this medication.

_____
Signature of Parent or Guardian Date