Mrs. Mac's Shining Stars
Medication Form

Child's Name: ____ Date: _____________________

Person authorized to give medication: ____
Teacher's Name

Prescription name: ____

Doctor's Name: ____

Dosage to be given: ____

Time to be administered: ____

Continue medication until (date) ____

Does medication need to be sent home daily? ______ yes ________ no

Parent Signature: ____

Date	Dosage	Given by

*****Teacher: Please keep this on your clipboard until medication no longer needs to be given, then please place this form in the child's file in your room.**