Lewis Cass Early Learning Academy

Medication Administration Form

Child's Name:		Date:
Start Date:	Stop Date:	
Medication Name:	Amount:	Frequency:
Parent/Guardian Signature:		Date:

Type of Medication ☐ Over the counter ☐ Prescription

☐ Oral ☐ Topical ☐ Other Reason:

(All medicines must be in the original container and we will follow lable/prescription instructions)

Medication Log

Date	Time	Amount	Comments	Signature