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: _____

Please submit to the office or email to gkirychuk@cbcaknights.org. Thank you!