CHILDREN/YOUTH PROGRAMS

MEDICATION INFORMATION FORM

1 To be completed by parent/guardian

Child's Name:	
Medication /Herbal remedy:	
Dosage amount:	
Dates to be given: Start date: Finish date:	Frequency of dosage:
Special Instructions (e.g. to be taken with food)	
Symptoms observed requiring administration of this medication/herbal remedy:	

- *Please note, all dosages must comply with the label on the medication unless stated by a doctor's note*

By signing this form, I hereby state that all the information provided above is true and understand its purposes in assisting staff with the safe distribution and/or administration of medication to my child/youth.

Signature of parent/guardian _____ Date _____

2 To be completed at time medication is administered

Date	Medication	Dosage	Time	Staff Signature

Date	Medication	Dosage	Time	Staff Signature