

# Prescription Medication Form

Child's Name: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

Any known allergies: \_\_\_\_\_

<u>PRESCRIPTION NAME</u>	<u>REASON</u>	<u>DOSAGE</u>	<u>TIMES/DAY</u>	<u>EXP. Date</u>

For the following time period beginning \_\_\_\_/\_\_\_\_/\_\_\_\_ and ending \_\_\_\_/\_\_\_\_/\_\_\_\_

Doctor's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Doctor's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone#: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Special Instructions/Notes: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_