Saint Brigid of Kildare Preschool
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Office of Early Learning and School Readines

Ohio | Department of Education

REQUEST FOR THE ADMINISTRATION OF PRESCRIPTION AND NON-PRESCRIPTION MEDICATION, FOOD SUPPLEMENT, FLOURIDE SUPPLEMENT, OR MODIFIED DIET

NOTE: A separate form must be completed for each medication.

SECTION I: PARENT REQUEST FOR ADMINISTRATION OF MEDICATION OR SUPPLEMENT

I hereby request and give permission to the authorized staff member to administer the following medication to my child:

Name of Child	Age of Child	Name of Medication or Supplement to be administered	
Dosage	Time(s) of Dosage	Signature of Parent/Guardian	Date

SECTION II: PHYSICIAN'S OR DENTIST'S INSTRUCTIONS:

Name of Child: _____ is under my care and should receive

Name of Medication or supplement _____

Dosage: _____

Specific instructions for administration: _____

Possible side effects: _____

Signature of Physician/Physician Assistant/Clinical Nurse Specialist/Certified Nurse or Dentist	Phone #
Please Print Physician's/Dentist's Name	Date

SECTION III: LOG OF MEDICATION OR SUPPLEMENT ADMINISTERED BY AUTHORIZED STAFF MEMBER

Date and Time of Dosage	Amount of Dosage	Signature of Authorized Staff Member