PARENT'S INSTRUCTIONS FOR MEDICATIONS!

Child's Name _____

Health Problem_____Name of Medication_____

Amount_____Times given at home_____

Please provide the following information:

Amount_____ Times to be given_____

How long medication to be continued_____

_____ _____

Date Parent signature

Record of administration (To be filled out by person who gives medication)

Date	Time	Amount	Initials	Date	Time	Amount	Initials

PARENT'S INSTRUCTIONS FOR MEDICATIONS!

Child's Name _____

Health Problem_____Name of Medication_____

Amount_____Times given at home_____

Please provide the following information:

Amount_____ Times to be given_____

How long medication to be continued_____

_____ _____

Date Parent signature

Record of administration (To be filled out by person who gives medication)

Date	Time	Amount	Initials	Date	Time	Amount	Initials