MEDICATION DISPENSE FORM

Child's Name: _____ Date: _____

Medication: _____

Prescribing Physician: _____

I _____, administered _____ of
(Parent's name) (Amount / Dosage)

_____ to my child _____,
(Name of medication) (Child's name)

at approximately _____ on _____
(Times to be administered) (Exact dates)

for _____.
(Reason for Medication)

- Possible side effects to watch for with this medication may include: _____
  _____

- Parent Signature: _____ Date: _____

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