MEDICATION ADMINISTERING INFORMATION

Participant's Name _____ Age _____

Parent/Guardian/Caregiver's Name _____

Home Phone _____ Daytime Phone _____

Cell Phone _____

Emergency Contact _____ Phone _____

Doctor's Name _____ Phone _____

Medication Information

1. Name _____ Time _____

Dosage_____ Route _____

Special Instruction _____

2. Name _____ Time _____

Dosage_____ Route _____

Special Instruction _____

3. Name _____ Time _____

Dosage_____ Route _____

Special Instruction _____

I understand that it is my responsibility to give the medication directly to staff with full instructions in the original prescription bottle. In all cases, medication administration can only be changed or modified by completing another *Medication Administration Information* form.
I hereby acknowledge that the above information provided for the administering of medication for the above named participant is accurate. I also understand that it is my responsibility to inform the agency if any changes in the administering of medication are necessary.

_____ Date _____
Signature of Parent/Guardian/ Caregiver