Taylor Chapel Academy Record of Prescription Medication

_____
School Year

Form expires at the end of the school year.

Child's Name: _____ D.O.B. _____

Prescription Number: _____

Prescription Name: _____

Physician's Name: _____

Dosage: _____

Route: _____

Administration Time Frame: _____

End Date: _____

REFRIGERATION NEEDED: ☐ YES ☐ NO ROOM TEMPERATURE: ☐ YES ☐ NO

Medication MUST be in the ORIGINAL container with PHARMACY label showing.

Parents Signature: _____

Staff Initials: _____

KEEP THIS COPY WITH MEDICATION

- -

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GIVE THIS COPY TO SUPERVISOR TO FILE.