BENOWA
early learning
CENTRE

MEDICATION FORM

Name: _____ Age: (Years) _____ (Months) _____

MEDICATION (Name)	Dosage and the way in which it is to be administered.	TIME	STAFF	WITNESS

DAYS REQUIRED:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY

Reason for the Medication: _____

_____

Is this an ongoing medication (i.e. Will apply indefinitely) Yes / No Date deleted: ____/____/____

Parent Signature: _____ Date: _____

Comment: _____

_____

Check by (Staff Name): _____ (Staff Signature): _____

****Note: This authority and directive will lapse after five days unless specific arrangements are made.**