Appendix M

Grandview Heights Christian Daycare Prescription Form

I request this medication to be given to ___________________________________and as parent or guardian: I assume responsibility for the results of this medication.

Prescription Number ____ Time to be given ____

Name of Medication ____ Needs Refrigeration ____

Physician's Name ____ Parent's Signature ____

Dosage ____ Date(s) to be given ____

Name any side effect to watch for: ____

STAFF USE ONLY:

Name of Medication	Dosage	Date Given	Time Given	Staff Initials

Safety Check:

1. Child resistant container
2. Original prescription or manufacturer's label with the name and strength of the medication and physician's directions for use (phone or written)
3. Name of child on container is correct for both first and last names
4. Current date on prescription/expiration label covers period when medication is to be given
5. Name and phone number of licensed health professional who ordered medication on container or on file
6. Instructions are clear for dose, route, and time to give medication

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