Rhode Island Department of Human Services

Medication Administration Form

Authorization		
To be completed by the parent/guardian.		
Child's Name:		**Route**
DOB:		☐ Mouth ☐ Eye: (Right / Left) ☐ Nose: (Right / Left) ☐ Ear: (Right / Left) ☐ Skin ☐ Other:_____
Medication:		
Refrigerated:	☐ Yes ☐ No	
Dosage:		
Schedule:		☐ Physician Ordered
Start Date:		
End Date:		Physician Name:
Reason for medication:		

I authorize to administer the _____
Provider/Program Name

to administer the following prescription medication or over-the-counter medication to the child named here. In addition, I will provide a list of potential side effects, obtained at the pharmacy, for prescription medications.

Parent/Guardian (Print)	Parent/Guardian Signature	Date

Medication Administration Log					
Staff Use Only: Complete each time medication is given to this child.					
Date	Time	Medication	Dosage	Notes	Staff Initials