NEVADA STATE UNIVERSITY
EARLY CHILDHOOD
EDUCATION CENTER

MEDICATION REQUEST

I am requesting that the following medication be administered to my child. I have provided a prescription for this medication (even if it is over the counter), it is in its original container with a child proof lid, and it is labeled with the name of my child.

Child's Name: _____ Medication Name/Dosage: _____

Dates to be given: _____ Times to be given: _____

Staff member who has been trained with administering medication: _____

Training provided by: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

ECEC Staff ONLY

Record of medication administration

Date/Time	Medication/Dosage	Person Administering