

# Distribution of Medicine

Child's Name: \_\_\_\_\_ Teacher's Name: \_\_\_\_\_

Name of Medicine: \_\_\_\_\_

*Provide instructions for the distribution of the prescribed medicine. Fill in the dates to administer, the time to administer, and the dosage.*

Date to Administer	Time to Administer	Dosage	Date Administered	Time Administered	Office Initials

Please provide any additional information needed:

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Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Distribution of Medicine

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Date to Administer	Time to Administer	Dosage	Date Administered	Time Administered	Office Initials

Please provide any additional information needed:

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Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_