

**MEDICATION REQUEST/PARENTAL CONSENT FORM**  
**Child Development Academy @ MU**  
**Fax (304) 696-5805**

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**PHYSICIAN'S ORDERS FOR MEDICATION ADMINISTRATION**

Child's Name: _____	Period of Treatment Date: _____ to _____
Name of Medication: _____	Form of Medication To Be Given: (circle below)
Dosage (amount to be given): _____	Tablet   Pill   Capsule   Liquid Inhalant   Other (specify) _____
Times of Administration: _____	Refrigeration? _____ Yes _____ No
Route of Administration: _____ (By mouth, nose, ear, etc.)	
Other specific instructions/conditions for administration: _____ _____ _____ _____	

Remarks: (Expected reactions, side effects, possible adverse reactions, food/drug interactions)

\_\_\_\_\_  
\_\_\_\_\_  
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Physician's Signature	Date	Telephone #
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**PARENT'S PERMISSION**

I hereby give my permission for my child (named above) to receive medication during center hours. I understand that the Child Development Academy at Marshall University undertakes no responsibility for the administration of medication. This medication has been prescribed by a licensed health professional. I hereby release Child Development Academy at Marshall University and its agents and employees from any liability that may result from my child taking this medication.

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Signature of Parent or Guardian	Date
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