MEDICATION ADMINISTRATION FORM

Innovations In Learning PC

Patient Name: _____ DOB: _____

Directions: Please complete the following information if your child is required to take prescription medication, over-the-counter medication or vitamins during the time he/she is at the ABA Clinic. Please complete all information below. All prescription medication is to be given to the Innovations staff in the original bottle with a label from the pharmacy. Over-the-counter medication must be in the original package with administration instructions in tact.

Prescribing Physician: _____ Phone: _____
(if applicable)

NAME OF MEDICATION/ VITAMIN	DOSAGE(S)	TIME ADMINISTERED	HOW ADMINISTERED (e.g. With pudding, in juice, swallows pills, etc)	POSSIBLE SIDE EFFECTS

_____ _____

Date Signature of Parent/Guardian