Medication Record

Child's Name: ____ DOB: _____________

I give The Family Support Center of Washington County permission to apply or administer any of the following external preparations or non-prescription medications checked in accordance with directions for use on the appropriate container only as necessary.

I authorize The Family Support Center of Washington County to administer prescription medication when necessary. I understand that prescription medications must be provided in the original container from the pharmacy, and will be administered according to the physician's orders. I also understand that a prescription cannot be given to a child whose name is not listed on the bottle.

Health/Disabilities:	**Brief Description**
Intellectual Y N	
Physical Y N	
Learning Y N	
Sensory Impairment Y N	
Special Health Conditions Y N	

Allergies (Food, Medications, etc.):

Should the child experience an allergic reaction, do you give the Family Support Center permission to administer Benadryl? YES NO

Bedwetting: Biting: Eating: Sleeping Problems: Special Fears:

Please Specify:

Signature: ____ Date: _______________