

CHILD'S INFORMATION

Child's Name:

Allergy /Medical Condition:

Medication Name:

Dosage:

Expiration Date:

Symptoms to look for before medication (Please be detailed):

Where is medication stored?

Plan after administration:

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name:

Parent /Guardian Name:

Emergency Contact Number:

Emergency Contact Number:

Alternate Number:

Alternate Number:

EMERGENCY CONTACT INFORMATION

Contact Name:

Phone Number:

Contact Name:

Phone Number:

SIGNATURES

Parent: _____

Date: _____

License Holder: _____

Date: _____