



Medication Staffing Form

Date: _____ Site: _____

Child's Name: _____

In Attendance: _____

History:

Symptoms to look for in the classroom: _____

Classroom Plan (includes type of medication, dose of medication and route of medication): _____

Follow up (if needed and by whom): _____

Expiration Date of Medication: _____

Expiration Date of Medication Authorization (no longer than one year): _____

**Information on Medication Form must match the information provided by the physician.

Original in Health Section of Child's File.
Copy goes to Health Program Manager
Copy stays WITH the medication.