

# Spring Creek UMC

## Prescription Medication Slip

***Please make copies if needed for more then one medication***

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Allergies: \_\_\_\_\_

I hereby authorize the staff of Spring Creek UMC to administer the following prescription medication to my child at the designated time.

Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_ Time: \_\_\_\_\_

Needs to be refrigerated: \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

Please administer medication: From \_\_\_\_\_ Through \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Medication Administered: \_\_\_\_\_ Student \_\_\_\_\_

Medication Administered: \_\_\_\_\_ Student \_\_\_\_\_  
Date: \_\_\_\_\_ Time: \_\_\_\_\_ Amount: \_\_\_\_\_ Person Administering Medication: \_\_\_\_\_ Initials: \_\_\_\_\_