Bright Beginnings Educare inc.

PLEASE ADMINISTER THE FOLLOWING MEDICATION TO: _____
START DATE: _____ PRESCRIBING PHYSICIAN_____
PRESCRIPTION NUMBER: _____
NAME OF MEDICATION: _____
HOW OFTEN TO ADMINISTER ANS WHAT TIMES: _____
CONTINUE MEDICATION UNTIL (DATE): _____
POSSIBLE SIDE-EFFECTS/CONCERNS: _____
_____

MEDICATION MUST BE IN ITS ORIGINAL CONTAINER WITH THE CHILD'S NAME CLEARLY TYPED, AS WELL AS INSTRUCTIONS FOR ADMINISTRATION.

SIGNATURE OF PARENT OR GUARDIAN: _____

DATE	TIME	DOSAGE	**PROVIDERS SIGNATURE**