Health Needs Form

Section I: Parent Request for Administration of Medication or Supplement

Name of Child	Age of Child	Name of Medication or Supplement to be Administered	
Dosage	Time(s) of Dosage	Signature of Parent/Guardian	Date

Section II: Physician's or Dentist's Insturctions:

Name of Child: ____ is under my care and should receive

Name of Medication or Supplement: ____

Dosage: ____

Specific Instructions for Administration: ____

Possible Side Effects: ____

Signature of Physician / Physician's Assistant / Clinical Nurse Specialist / Certified Nurse / Dentist	Phone Number
Please Print Name	Date

Section III: Modified Diet Information

Name of Child: ____

Description of Special Dietary Needs:

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Section IV: Log of Medication or Supplement Administered by Authorized Staff Member

Date and Time of Dosage	Amount of Dosage	Signature of Authorized Staff Member

Date and Time of Dosage	Amount of Dosage	Signature of Authorized Staff Member