Medical Professional Signature:

Effective Date: 11/11/2011

MTL0207-11042011 Section 0207 Subject: Health Services

**Prescription Medication Explanation** DOB: Child Name: Date: Caregiver Name and Address: Prescribing Medical Professional Name and Address: (Please sign at bottom of page) **Medication:** Phone: # Units: Dosage: Times per Day: **Duration: Child's Need for Medication: Effect of Medication on Child:** 

Date: