

Participant Name: _____
 Parent/Guardian Name: _____
 Day Phone: _____ Eve. Phone: _____



The Leadership School
 at **Kieve**

School/Organization: _____

Kieve-Wavus Education, Inc, PO Box 169, Nobleboro, Maine 04555
 Tel. 563-6212 Fax 563-5833

Medication Administration Form

Please only complete this form if the participant needs to take medication while at The Leadership School. Complete one row for each medication. Please send medication in original packaging clearly labeled with the participant’s name and instructions. Please provide the appropriate amount for the duration of the participant’s stay. (Make additional copies of this form if necessary)

Medication Name (Dose)	Time of Administration	M	T	W	Th	F	S	S
	<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> As Needed <input type="checkbox"/> Other _____	For Staff Use						
	<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> As Needed <input type="checkbox"/> Other _____	For Staff Use						
	<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> As Needed <input type="checkbox"/> Other _____	For Staff Use						