

CHILD DEVELOPMENT SERVICES (CDS) MEDICAL DISPENSATION RECORD	MONTH _____
<small>For use of this form, see AR 608-10; the proponent agency is DCSPER.</small>	

(SEE REVERSE FOR PRIVACY ACT STATEMENT)

NAME OF CHILD _____	ACTIVITY ROOM _____	NAME OF SPONSOR _____	HOME PHONE _____	DUTY PHONE _____
MEDICATION <i>(One per card)</i> _____	AUTHORIZING PHYSICIAN _____	MEDICAL FACILITY _____	TELEPHONE _____	
INCLUSIVE DATES	DOSAGE	TIME	INSTRUCTIONS: REFRIGERATION <input type="checkbox"/> YES <input type="checkbox"/> NO	
BEGIN _____	_____	_____		
FINISH _____	_____	_____		

*CDS PERSONNEL DISPENSING MEDICINE WILL INDICATE TIME OF ADMINISTRATION AND INITIAL SAME WITHIN EACH TIME BLOCK ON A GIVEN DATE.

*1 _____ _____	*2 _____ _____	*3 _____ _____	*4 _____ _____	*5 _____ _____	*6 _____ _____	*7 _____ _____
*8 _____ _____	*9 _____ _____	*10 _____ _____	*11 _____ _____	*12 _____ _____	*13 _____ _____	*14 _____ _____
*15 _____ _____	*16 _____ _____	*17 _____ _____	*18 _____ _____	*19 _____ _____	*20 _____ _____	*21 _____ _____
*22 _____ _____	*23 _____ _____	*24 _____ _____	*25 _____ _____	*26 _____ _____	*27 _____ _____	*28 _____ _____
*29 _____ _____	*30 _____ _____	*31 _____ _____				

