

Medication Administration Log

School/Childcare Program _____

Child's Name: _____ Date of Birth: _____

Medication: _____ Dosage: _____ Route: _____

To be given at the following time: _____ Medication expiration date: _____

Start Date for Medication: _____ End Date: _____

Special Instructions: _____

Health Care Provider Prescribing Medication: _____ Phone: _____

Parent name: _____ Parent Phone #: _____ Parent Phone #: _____

Week of:

Week of:

	Mon Date	Tue Date	Wed Date	Thurs Date	Fri Date	Mon Date	Tue Date	Wed Date	Thu Date	Fri Date
A. M.										
P. M.										

Include Time Medication was Given and Initials If the child is absent, mark box with an "A"; If the medication was not given, mark box "NG" . Document reason medication was not given in Comments.

Intake and Count for All Medication

Note- All controlled medications must be counted and verified by two medication trained staff members or by one staff member and parent (i.e.: Ritalin, Dexedrine and Tylenol with codeine)

Date	Name of Medication and Dosage	Expiration Date	Amount Received	Parent Signature	Staff Initials

Staff Signatures

Initials
