

Medication Record

Child's Name:	
Medication:	
Dosage:	
Start Date:	Finish Date:
Time to Administer:	
Special Instructions (e.g. to be taken with food):	
Prescribing Physician's Name:	
Date:	
	Signature of Parent/Guardian
	Signature of Program Supervisor/Director

To be completed by Staff Member at the time of medication given

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Date	Medication	Dosage	Time	Staff Signature		