MEDICATION RECORD and PARENT AUTHORIZATION

Child's Name: _____

Name of Medication: _____

Amount of Dosage: _____ Administered When: _____
(1 tablet, 1 teaspoon) *Time(s) of Day*

Administered How: _____
Describe - Orally? Topically?

Administered From: _____ To: _____
Date *Date*

Authorized By: _____ Date: _____
Parent(s) / legal guardian(s) signature

DATE MEDICATION ADMINISTERED	TIME MEDICATION ADMINISTERED	ADMINISTERED BY Signature / Initials

The following staff were trained by _____ on _____ to administer this medication.
Trainer's Name Date

Staff Names: _____

FOR AS NEEDED DOSING INSTRUCTIONS: The following are the symptoms that indicate that this medication should be administered: _____