Medication Administration Record

(to be completed in ink only)

Child's Name: ____

Medication: ____

Amount To Be Given: ____

Dates To Be Given: start date: ________________
finish date: ________________ (maximum 2 weeks)

Exact Times to Be Given: ____________________________________

Special Instructions: (e.g. to be taken with food)

____

Mediation Given At Home: __________________________ Time: ______

Date: __________ Signature of Parent/Guardian: ___________________

To Be Completed By The Staff Member Administering the Medication At The Time It Is Given:

DATE	MEDICATION	DOSAGE	TIME	STAFF SIGNATURE

* This form is to be used when a child is on medication for a longer period of time, or when individual medication records are required