Camrose
Caring for Children
children's
Since 1968
Centre

INDIVIDUAL "PRESCRIPTION" MEDICATION RECORD

PLEASE NOTE: This form to be used when a child is on medication for an extended period of time, or when individual medication records for each child are required.

ONE SHEET PER MEDICINE PLEASE **To be completed by parent/guardian.**

FOR INHALERS (ASTHMA) PER MONTH

Child's Name _____

Medication:

Prescription #: _____

Doctors Name: _____

Medication/Herbal Remedies given prior to arriving at the Day Home, including times:

_____ Parent Initial: _____

Amount to be Given: _____

Dates to be Given : Start date _____

Finish date _____

When to be Given: _____

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

_____

Date: Signature of Parent/Guardian:

_____ _____

To be completed by the staff at the time medication is given

Time	*Medication*	*Dosage*	*Date*	*Staff Signature*	*First Aid*