INDIVIDUAL MEDICATION RECORD

NON-PRESCRIPTION MEDICATION / HERBAL REMEDY

To be completed be parent/guardian

CHILD'S NAME: ____________________

MEDICATION: ____________________

HAS YOUR CHILD TAKEN THIS EXACT MEDICINE BEFORE? __________
DID YOUR CHILD HAVE ANY REACTIONS: __________
Medications given prior to arriving at the Day Care, including times:
____________________ Parent Initial: ______

WHEN DID YOUR CHILD LAST TAKE THIS MEDICINE? __________

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): __________

____

DATE: ____________________

SIGNATURE OF PARENT/GUARDIAN: ____________________

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

DATE	MEDICATION	DOSAGE	TIME	STAFF SIGNATURE	FIRST AID

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