

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 / MEDICINE PLEASE *To be completed by parent/guardian.

If for inhalers/epi-pens may be completed for one month at a time.

Name:

Child's Name:		
Medication:	····	
Prescription #:		
	SS-T-MARKET	•
Medication/Herbal	Remedies given prior to arriving	at Day Care, including times: Parent Initial:
Amount to be Giver	1:	
Dates to be Given:	Start date:	
	Finish date:	(maximum 2 weeks)
Exact times to be G	iven:	-
Specific Instruction	i. (i.e. 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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