Medication Record

Child Name: _____ **D.O.B**: ____/____/____

To be completed by child's parent/guardian

Name of Medication:	
Last Administered Date: ____/____/____ Time: _____ am/pm	
Time & Date: To be Administered: (or under circumstances to be administered Date: ____/____/____ Time: _____ am/pm Other information:	
Dosage Required:	Method of Administration:
Name of child's parent/guardian:	
Signature of child's parent/guardian:	

To be completed by educator when medication administered

Medication Administered Date: ____/____/____ Time: _____ am/pm	
Dosage Administered:	Method of Administration:
Name of educator administering:	
Signature of educator administering:	
Name of witness:	
Signature of witness:	