

DAILY MEDICATION RECORD
(TO BE COMPLETED FOR ANY AND ALL MEDICATIONS)

Child's Name: _____ Today's Date: _____
Illness/Condition: _____

Medication (please specify product name): _____
Prescription: _____ Non-Prescription _____

Dosage: Amount: _____ Time(s) to be given: _____
Length of Treatment: _____ Proper storage: shelf _____ refrigerator _____

Time of last dose: _____

Special Instructions: _____

Adverse Reactions? Y _____ N _____ If yes, explain _____

PARENT SIGNATURE: _____
Daytime Telephone: _____

DATE	TIME	DOSAGE	STAFF INITIALS	ADVERSE EFFECTS	ERRORS (if any)

Parents must be notified immediately of any adverse reactions to medication administered and any medication error.