

MEDICATION ADMINISTRATION PERMISSION & RECORD

Information about the child and the medicine
(Completed by parent/guardian)

Child's Name			Child's Date of Birth	
Medicine	Time	Date	Dosage	Route
Expiration Date:				
Special Instruction:				
Possible Reactions:				
Prescribing provider:			Phone:	
Pharmacy:			Phone:	
I give authorization to give medicine and to call the health care provider if needed. Parent/Guardian signature				Date
RETURNED to Parent/Guardian	Date	Parent/Guardian signature		Child Care Staff signature
DISPOSED of Medicine	Date	Child Care Staff signature		Witness signature

Medication Log
(Completed by child care provider)

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date					
Actual time given	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____
Dosage/Amount					
Route					
Facility staff's Signature					

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date					
Actual time given	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____
Dosage/Amount					
Route					
Facility staff's Signature					

	Monday	Tuesday	Wednesday	Thursday	Friday
Medicine					
Date					
Actual time given	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____	AM _____ PM _____
Dosage/Amount					
Route					
Facility staff's Signature					

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Date					
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Dosage/Amount					
Route					
Facility staff's Signature					

Describe error or mishap in a Medical Error Form

Date/time	Error/Mishap	Parent/Guardian Notified?	Child Care Staff Signature
		__Yes __No	
		__Yes __No	