

Log 2 Week Medication Administration

School/Child Care:			
Child's Name:		Birthdate:	Classroom:
Medication:	Dosage:	Route:	Time to be given:
Start Date:	End Date:		Expiration Date:
Special Instructions:			
Health Care Provider Prescribing Medication:			Phone:
Parent Name:		Parent Work Phone:	Parent Cell Phone:

Time	Week of:					Week of:				
	Mon Date:	Tue Date:	Wed Date:	Thurs Date:	Fri Date:	Mon Date:	Tue Date:	Wed Date:	Thurs Date:	Fri Date:
AM:										
AM:										
PM:										
PM:										

Include time medication given and initials. If child absent, mark box with "A"; If medication not given, mark box "NG". Document reason not given in comments.

Date & Comments:

Staff Signatures	Initials

Intake and Count for All Medication

All controlled medications must be counted and verified by two medication trained staff members or by one staff member and parent (i.e. Ritalin, Dexedrine)

Date	Name of Medication and Dosage	Expiration Date	Amount Received	Parent Signature	Staff Initials

