

MEDICATION LOG

CHILD'S NAME: _____ D.O.B.: _____ ALLERGIES: _____

PARENT'S/GUARDIAN'S NAME: _____ DR: _____ TELEPHONE: _____

MONTH: _____

MEDICATION INFO	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		
DRUG:																																		
DOSAGE:																																		
ROUTE:																																		
REASON:																																		
DATE START:																																		
DATE END:																																		
SP. DIR.:																																		

I, the parent or guardian of the above child give permission for the above medication to be administered.

Signature _____
Date

MEDICATION INFO	TIME	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31			
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MEDICATION LOG (Cont'd)

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Signature

Date

DATE	TIME	COMMENTS

NAME OF PERSON ADMINISTERING	INITIALS	ROUTES OF ADMINISTRATION:
		ORAL (BY MOUTH)
		EYE DROPS (OPTIC)
		NOSE DROPS (SPRAY) (NASAL)
		EAR DROPS (OTIC)
		TOPICAL (ON SKIN)