Medication Form *(Please fill out a separate sheet for each medication)*

Date: _____

Name of Child: _____

Name of Medication *(exactly what is written on the label)*

_____

_____

Is this an ongoing medication? *(Example: YES if Tylenol for teething, puffer etc. NO for all others)*

_____

Dosage*: (Must match what is written on the med label)*

_____

Symptoms: *(Please be as specific as possible; Example: If for teething: irritable, fever of ____, red cheeks etc. or if for cough: length, intensity, type (dry), wheezing etc.)*

_____

_____

_____

Time of Administration: *(Example: as needed every 4-6 hours or specific time of day)*

_____

Start Date of medication: _____

End Date/Expiry Date: *(Date med is to be done/ Expiry date. *Please include both if med is ongoing)*

_____

Storage instructions: *(fridge or room temp in cabinet)* _____

Parent Signature: _____

Date	Time	Dosage	Comments/Reason	Staff Signature