MEDICATION RECORD

Child's Name: _____

Medication	Start Date	End Date	Corresponding Condition	Dosage	Displayed Symptoms Requiring Medication	Special Instructions (eg. To be taken with food)

Signature of Parent/Guardian:_____ Date: _____

To be completed by the staff at the time medication is given:

DATE	MEDICATION	DOSAGE	TIME	STAFF SIGNATURE	FIRST AID CERTIFICATION

This form is to be kept in child's file once it is completed.