

MEDICATIONS RECORD



Child's Name: _____

Month/Year: _____

Incoming Medication Log

Medication	Doctor	Pharmacy	RX No.

Parents' Notes (reason for missed medication, concerns, etc.)

Dates	Times	Comments

NOTE: All medications must be destroyed according to the printed expiration dates. All medications must be kept in a locked container and out of the reach of children.

Med/ Dosage	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					

Each time medication is given, parent is to initial the square corresponding to the date and time given. Please sign and initial below.

Parent #1 Signature: _____ Initial _____

Parent #2 Signature: _____ Initial: _____