|  |  |  |  |
| --- | --- | --- | --- |
| Child’s Name (first and last): | | | |
| Name of Medication (as it is appears on medication container): | | | |
| **\*\* If a medication was not given, you must document the reason why. \*\*** | | | |
| Date | Time | Dosage | Side Effects Observed (if any) |
|  |  |  |  |
| Name of person who gave medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(print name) (signature)* | | | |
| Date | Time | Dosage | Side Effects Observed (if any) |
|  |  |  |  |
| Name of person who gave medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(print name) (signature)* | | | |
| Date | Time | Dosage | Side Effects Observed (if any) |
|  |  |  |  |
| Name of person who gave medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(print name) (signature)* | | | |
| Date | Time | Dosage | Side Effects Observed (if any) |
|  |  |  |  |
| Name of person who gave medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(print name) (signature)* | | | |
| Date | Time | Dosage | Side Effects Observed (if any) |
|  |  |  |  |
| Name of person who gave medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(print name) (signature)* | | | |
| Date | Time | Dosage | Side Effects Observed (if any) |
|  |  |  |  |
| Name of person who gave medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(print name) (signature)* | | | |
| Date | Time | Dosage | Side Effects Observed (if any) |
|  |  |  |  |
| Name of person who gave medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(print name) (signature)* | | | |
| Date | Time | Dosage | Side Effects Observed (if any) |
|  |  |  |  |
| Name of person who gave medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(print name) (signature)* | | | |