Medication form

(short term-less than 2 weeks)

Please check if the medication needs to be given with food/before food to ensure times are filled in correctly.

Childs name		Date:
Name of medication:	Reason for medication:	
Has the medication been prescribed? (this includes recommendation from a pharmacist)		Yes/No

Date:			Date:		
Dosage required: Time(s):			Dosage required: Time(s):		
Signed:			Signed:		
Below to be filled in by staff			Below to be filled in by staff		
Date:	Dose		Date:	Dose	
Time:		Administered by: Witness:	Time:		Administered by: Witness:
Time:		Administered by: Witness:	Time:		Administered by: Witness:
Parent signature at the end of the day:			Parent signature at the end of the day:		

Date:			Date:		
Dosage required: Time:			Dosage required: Time:		
Signed:			Signed:		
Below to be filled in by staff			Below to be filled in by staff		
Date:	Dose		Date:	Dose	
Time:		Administered by: Witness:	Time:		Administered by: Witness:
Time:		Administered by: Witness:	Time:		Administered by: Witness:
Parent signature at the end of the day:			Parent signature at the end of the day:		

*ask parent if they would like a copy

If medication is continued for more than 4 days - please staple sheets together.