CROSSROADS FAMILY SERVICES ph: 780.430-7715 ~ #201-1207-91 St. SW, Edmonton AB T6X 1E9 main@crossroadsfs.ca fax: 780.430-7778

MEDICATION ADMINISTRATION RECORD	Child:	Prescribing Doctor:	Month/Year:

PRESCRIBED MEDICATION / SLEEP AIDS **Person administering the medication initials the appropriate block. (See Key below)**

REMINDER: *Sleep drugs and Mind & mood altering drugs MUST have* ***written CI Practitioner approval*** *on the child's file before filling the prescription.*

Medication Name Dose/Route		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	Initials																
		17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Times:	Initials																
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	Initials																
Times:		17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
	Initials																
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	Initials																
Times:		17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
	Initials																

KEY: ***S*** *– School Administered*
FV *- Family Visit*
Caregiver will initial

If any of the following took place, please document:

☐ Refusal to take medication (Incident Report) Date(s) of Medication Incident:
☐ Medication error (Incident Report)
☐ Adverse reaction (Critical Incident Report)

NON- PRESCRIPTION (e.g., Ibuprofen, cough or cold medicine, vitamins, herbal medications)

REMINDER: ***Before first time use of any non-prescription medications,*** *consult with a doctor / qualified health care professional for approval - consult includes Med Review.*

Medication Dose/Route		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	Initials																
		17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
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	Initials																

Caregiver Signature: _____