



MEDICATION ADMINISTRATION RECORD	Child:	Prescribing Doctor:	Month/Year:
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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 caseworker 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
Times:	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
Times:	Initials																
		17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
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		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

KEY: *S – School Administered* **If any of the following took place, please document:** Refusal to take medication (Incident Report) Date(s) of Medication Incident:
FV - Family Visit Medication error (Incident Report)
Caregiver will initial 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
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Caregiver Signature: _____