MEDICATION LOG

CHILD'S NAME: _____ **D.O.B.:** _____ **ALLERGIES:** _____

PARENT'S/GUARDIAN'S NAME: _____ **DR:** _____ **TELEPHONE:** _____

MONTH: _____

MEDICATION INFO	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
DRUG:																																
DOSAGE:																																
ROUTE:																																
REASON:																																
DATE START:																																
DATE END:																																
SP. DIR.:																																

I, the parent or guardian of the above child give permission for the above medication to be administered.

Signature _____ **Date** _____

	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
DRUG:																																
DOSAGE:																																
ROUTE:																																
REASON:																																
DATE START:																																
DATE END:																																
SP. DIR.:																																

I, the parent or guardian of the above child give permission for the above medication to be administered.

Signature _____ **Date** _____

	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
DRUG:																																
DOSAGE:																																
ROUTE:																																
REASON:																																
DATE START:																																
DATE END:																																
SP. DIR.:																																

I, the parent or guardian of the above child give permission for the above medication to be administered.

Signature _____ **Date** _____

MEDICATION LOG *(Cont'd)*

MEDICATION INFO	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
DRUG:																																
DOSAGE:																																
ROUTE:																																
REASON:																																
DATE START:																																
DATE END:																																
SP. DIR.:																																

I, the parent or guardian of the above child give permission for the above medication to be administered.

Signature _____ **Date** _____

DATE	TIME	COMMENTS

NAME OF PERSON ADMINISTERING	INITIALS

ROUTES OF ADMINISTRATION:
ORAL (BY MOUTH)
EYE DROPS (OPTIC)
NOSE DROPS (SPRAY) (NASAL)
EAR DROPS (OTIC)
TOPICAL (ON SKIN)