Camrose Children's Centre

INDIVIDUAL MEDICATION RECORD
NON-PRESCRIPTION MEDICATION /HERBAL REMEDY
TO BE COMPLETED BY PARENT/GUARDIAN

CHILD'S NAME: _____
MEDICATION: _____
HAS YOUR CHILD TAKEN THIS EXACT MEDICATION BEFORE? _____
DID YOUR CHILD HAVE ANY REACTIONS? _____
ANY OTHER MEDICATIONS GIVEN PROIR TO ARRIVING? _____
IF YES WHAT WERE THEY AND TIME: _____

WHEN DID YOUR CHILD LAST TAKE THIS MEDICATION? _____
AMOUNT TO BE GIVEN: _____
DATES TO BE GIVEN: Start Date _____
Finish date _____ (MAXIMUM TWO WEEKS)

EXACT TIMES TO BE GIVEN: _____
SYMPTOMS OF "AS NEEDED" (e.g., fever, teething, needles, ect) _____
SPECIAL INSTRUCTIONS (e.g., to be taken with food): _____
DATE: _____
SIGNATURE OF PARENT/GUARDIAN: _____

TO BE COMPLETED BY THE STAFF ACCEPTING FORM AND MEDICATION:
MEDICATION IS IN THE ORIGINAL BOTTLE: _____
MEDICATION IS LABELED WITH CHILD NAME: _____
DOSAGE CORRESPONDS WITH LABEL INSTRUCTIONS OR DOCTOR'S ORDER: _____
STAFF RECEIVING THIS MEDICATION: _____

To be completed by the staff at the time medication is given

5 RIGHTS	DATE	MEDICATION	**SYMPTOM REASON**	DOSAGE	TIME	STAFF SIGNATURE	DO YOU HAVE FIRST AID