Camrose Children's Centre

INDIVIDUAL MEDICATION RECORD
PRESCRIPTION MEDICATION
TO BE COMPLETED BY PARENT/GUARDIAN

CHILD'S NAME: _____
MEDICATION: _____
PRESCRIPTION #: _____
DOCTORS NAME: _____
MEDICATION/HERBAL REMEDIES GIVEN PRIOR TO ARRIVING, INCLUDING TIMES:
_____PARENT INTIAL: _____
AMOUNT TO BE GIVEN: _____
DATES TO BE GIVEN: Start Date _____
Finish date _____ (MAXIMUM TWO WEEKS)

EXACT TIMES TO BE GIVEN: _____
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	*DOSAGE*	*TIME*	*STAFF SIGNATURE*	*DO YOU HAVE FIRST AID*