MEDICATION RECORD

To be completed by parent/guardian

CHILD'S NAME: _____ BIRTHDATE: _____

MEDICAL CONDITION: _____

MEDICATION: _____

DOSAGE: _____

EXACT DATE & TIMES TO BE GIVEN: _____

SPECIAL INSTRUCTIONS: (eg. To be taken with food) _____

_____

SIDE EFFECTS: _____

PARENT OR GUARDIAN: _____

PHONE (home) _____ (work) _____

If the above person is not available in an emergency please notify:

_____ PHONE (home) _____
(work) _____

We, the parents/guardians, hereby waive all rights of action on behalf of ourselves and/or our child in case of any cause of action that may arise as a result of the principal/designate proceeding with our request for administering medication/personal care.

SIGNATURE OF PARENT/GUARDIAN _____DATE: _____

To be completed by the supervisor at the time medication is given:

DATE	**MEDICATION**	**DOSAGE**	**TIME**	**SUPERVISOR SIGNATURE**