EARLY LEARNING COALITION OF SOUTHWEST FLORIDA

Regular Medication Administration Record

<u>Directions:</u> This form is to be used whenever a child is to receive a <u>regularly scheduled medication.</u> ***Parent*** *will complete upper portion of form, using separate form for each medication. Form is <u>valid for two weeks</u>. If medication is to continue beyond that time, parent will complete additional forms.*

Staff *will fill in date, time and signature/initial for each dose of medication administered, after completing Medication Administration Safety Checklist. When medication is finished, all paperwork is stored in child's record.*

Child's Name ________________________________ Birth date ______________

Medication Name _______________________________ Dosage __________________

Time(s) Med to be given at Center each day [1st Dose @] [2nd Dose @]

Route of Medication (ex: oral, right eye, left ear, etc) _________________________________

Date Medication to START _______and STOP _______ Side Effects ____________________

Reason for Medication ____

Name of ordering Physician __________________________ Phone _____________________

I hereby give permission for CCSWFL staff to give this medication to my child.

_________________________________ ________________ ________________

Parent/Guardian Signature Date Phone

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Date	Time #1	Signature	Initials √	Time #2	Signature	Initials √