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| Month/Year: |  | Child’s Name: |  |

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| Physician’s Name: |  | Date First Given This Month |  | Date Last Given This Month |  |

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| Name & Strength of the Drug: |  | Dosage & Frequency: |  |
| Reason for Medication: |  | Medication Allergies: |  |

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| **Person Administering Medication** | **Date** | **Time Given** | **Amount Given (dosage)** |
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\*\*If medication is not given as prescribed, please explain circumstance on separate page and attach to log

\*\*Person administering medication must sign name initially and then initials may be used. Additional individuals administering must sign full signature and then use initials.

Printed Name Signature Initials

Printed Name Signature Initials

Printed Name Signature Initials

Printed Name Signature Initials