Medication Administration Log

Name of Child:_____ DOB:___/___/_____ Grade:_____

Medication:_____ Start Date: ___/___/___ End Date:___/___/___

Dosage:_____ Form (cap, tab, liquid)_____ Time(s) to be given:_____

Instructions: _____

Physician: _____ Phone #:_____

For “as needed” medications:

Symptoms for which medication is administered:_____

Length of time medication is allowed to be given on “as needed” basis:_____

Maximum amount of medication allowed in a 24-hour period:_____

Date	Time	Amount Given	Printed Name of Person Administering	Signature of Person Administering

Date	Time	Amount Given	Description of Error in Administration OR Adverse Reaction	Print Name / Signature

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