



## Family Day Home Program

### INDIVIDUAL MEDICATION RECORD - NON-PRESCRIPTION MEDICATION HERBAL REMEDY

*To be completed by parent/guardian.*

CHILD'S NAME \_\_\_\_\_

MEDICATION \_\_\_\_\_

HAS YOUR CHILD TAKEN THIS EXACT MEDICINE BEFORE? \_\_\_\_\_

\_\_\_\_\_

DID YOUR CHILD HAVE ANY REACTIONS? \_\_\_\_\_

WHEN DID YOUR CHILD LAST TAKE THIS MEDICINE? \_\_\_\_\_

AMOUNT TO BE GIVEN \_\_\_\_\_

DATES TO BE GIVEN: *Start date* \_\_\_\_\_

*Finish date* \_\_\_\_\_ (maximum 2 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 at the time medication is given**

DATE	MEDICATION	DOSAGE	TIME	STAFF SIGNATURE	FIRST AID