

Camrose Family Day Home Program

INDIVIDUAL MEDICATION RECORD

NON-PRESCRIPTION MEDICATION HERBAL REMEDY

Medication/Herbal Remedies given prior to arriving at the Day Home, including times:
_____ **Parent Initial:** _____

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