MEDICATION LOG FORM



PLEASE PRINT

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| NAME |  | | | | | | | | | | | | | | | | | | |
| DATE OF BIRTH | | |  | | | | | | | | | | | | | | | | |
| ALLERGIES | |  | | | | | | | | | | | | | | | | | |
| MAJOR MEDICAL CONDITIONS | | | |  | | | | | | | | | | | | | | | |
| EXAMPLE | | | | | SAT | | # | SUN | # | MON | # | TUES | # | WED | # | THUR | # | FRI | # |
| MEDICATION | | | Zrytec | | Example:  Our health care staff will fill in the daily amount and time the medication was administered. | | | | | | | | | | | | | | |
| DOSE | | | 1 Pill | |
| ROUTE | | | Orally | |
| COMMENTS | | | Daily AM | |
|  | | |  | | SAT | | # | SUN | # | MON | # | TUE | # | WED | # | THUR | # | FRI | # |
| MEDICATION | | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |
| DOSE | | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ROUTE | | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |
| COMMENTS | | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |
| MEDICATION | | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |
| DOSE | | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ROUTE | | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |
| COMMENTS | | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |
| MEDICATION | | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |
| DOSE | | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ROUTE | | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |
| COMMENTS | | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |
| MEDICATION | | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |
| DOSE | | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ROUTE | | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |
| COMMENTS | | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | | | | |  |  | | | | | | |  |  | | | | | |
| **PARENT PRINTED NAME** | | | | |  | **PARENT’S SIGNATURE** | | | | | | |  | **DATE** | | | | | |
| **HEALTH CARE STAFF PRINTED NAME** | | | | |  | **HEALTH CARE STAFF** | | | | | | |  | **DATE** | | | | | |