# Calvary Preschool

## Medication Administration Log

Child's Name:_____     Date of Birth: _____

Medication:_____     Dosage: _____

Start Date for Medication:_____     End Date: _____

Special Instructions: _____

_____

_____

Name of Medical Doctor Prescribing Medication: _____
Phone #:_____

Parent Name:_____

Cell #: _____     Work #:_____

| Week of: | | | | | | Comments: |
|----------|-----|------|-----|-------|-----|-----------|
|          | Mon | Tues | Wed | Thurs | Fri |           |
| AM       |     |      |     |       |     |           |
| PM       |     |      |     |       |     |           |

- Include time medication was given and Initial.
- If the child is absent, mark box with an **A**. If the medication was not given, mark box with **NG**.
- Document reason medication was not given in the comments section.

| Staff Signature | Initials | Staff Signature | Initials |
|-----------------|----------|-----------------|----------|
| Staff Signature | Initials | Staff Signature | Initials |