LITTLE TREASURES LEARNING CENTER

Individual Medication Record

Child's Name _____

Name of medication _____

____ Prescription ____ Non-Prescription with Doctor's approval

Reason for medication _____

Amount to be administered _____

Times to be administered _____

Refrigeration needed? ____Yes ____No

Possible adverse reactions _____

Parent's signature _____

Staff member who will be administering the medication _____

Date	Time	Reaction	Staff's Initial