Communities Connected for Kids

Please submit the completed form to our office by the 5th of each month.

Medication Administration Log

Child's Name:		*DOB:*	

Medication & Prescribing Physician	*Dosage*	*Reason for Medication*	*Frequency & Time of Day*	*MONTH OF _____, YEAR OF_____*																											
				1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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Medication Allergies: 1._____ 2._____ 3._____	My signature/initial indicates that I have, **on a daily basis**, administered or monitored self-administered prescribed dosage as evidenced by my initials on the medication log.			
	Caregiver Name	**Caregiver Signature**	**Caregiver Initial**	**Key** **R-R**efused **C-** Crisis Unit or ER **M-**Missed **D-**DJJ/Detention
Notes:				