RECORD OF MEDICATION/TREATMENT ADMINISTERED

(To record medication/treatment given on a regular basis)

NAME: _____ BIRTHDATE: _____

ADDRESS: _____ PHONE: _____

SCHOOL: _____ GRADE: _____

Please initial under the appropriate date for each medication/treatment administration. If any deviations or side effects, please describe on back of this page.

Medication or Treatment	Dose	Time	Date						Month						Year:					

All persons who make one or more administration(s) during the month must sign and initial in a space below:

Signature	Initial	Signature	Initial	Signature	Initial
Signature	Initial	Signature	Initial	Signature	Initial