MEDICATION LOG

55 Pa. Code §3270.133; §3280.133; §3290.133
PLEASE PRINT

Page _____ of _____

Child's Name: _____ Medication: _____

☐ Prescription ☐ Non-Prescription Refrigeration Required: ☐ YES ☐ NO Expiration Date: _____

PLEASE NOTE:
Any over the counter medication (i.e. Acetaminophen, Ibuprofen or Allergy Medication, etc. must be accompanied by a doctors script if the child is under age 2 or under 24 lbs. The script must state proper dosage for each child.)

If Prescription, Prescriber's Name: _____ Telephone: _____

Dosage Amount: _____ Time to Administer: _____ a.m. _____ p.m. _____ times/day

Dates for Administration: From _____To _____ (6 months max.) Route:_____

JB's Bright Beginnings may not administer the 1st dosage of any new medication to your child.

☐ Check here to confirm this will not be the first dose and your child has received his medication before.

Special instructions: (symptoms signaling need for administration, medication indications, or reasons to hold medication)

_____

_____

I give permission to administer medication to my child as stated above.

_____ _____
PARENT SIGNATURE DATE

FACILITY STAFF COMPLETE THIS SECTION

Date Administered (mm/dd/yyyy)	Time Administered (a.m. / p.m.)	Amount of Medication Administered	Reason for Administering	Reactions/Comments Health Check ~ 30 Minutes After Administering	ROUTE: Ear, Mouth Nose, or Eye	Staff Initials

This information is confidential and may not be shared or released without the parent's written permission.