Boys & Girls Clubs of the Foothills
Great futures start here

INDIVIDUAL MEDICATION RECORD

To be completed by parent/guardian.

CHILD'S NAME:_____

MEDICATION: _____

AMOUNT TO BE GIVEN: _____

DATES TO BE GIVEN: Start Date: _____

Finish Date: _____

SYMPTONS TO OBSERVE OR SPECIAL INSTRUCTIONS: _____

DATE: _____ SIGNATURE OF PARENT/GUARDIAN:_____

To be completed at the time medication is administered
*Parent approval for the administration of medication or herbal remedy must be renewed monthly

DATE	MEDICATION	DOSAGE	TIME	STAFF SIGNATURE