DSS-106 A-5
R. 4/98

MEDICATIONS ADMINISTRATION RECORD for _____ (month/year)

Child's Name: _____ DOB: _____ Height: _____ Weight: _____

Pharmacy Address and Phone #: _____ Medication Allergy: _____

	Time	Day 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	Refill Due Date:
1. Medication:																																	
For:																																	
Dosage:																																	
2. Medication:																																	
For:																																	
Dosage:																																	
3. Medication:																																	
For:																																	
Dosage:																																	
4. Medication:																																	
For:																																	
Dosage:																																	
5. Medication:																																	
For:																																	
Dosage:																																	

Comments (reactions, side effects experienced, etc.). Use additional sheet if necessary: _____

_____

_____

File: Original, Passport Folder
Copy, Professional, Section III.