Log – Daily - Controlled Medications Administered Use one sheet for each child and each medication

School/Chi	ld Care Program:					
Child's Name:			Birth Date:		Classroom:	
Medication:			Dosage:		Route	
Time medi	cation to be given:		•			
Length of time medication is to be given:			Start Date:		End Date:	
Special Ins	structions:					
Name of H	ealth Care Provider Prescrib		Phone:			
All med	ication received must	be counted and	signed by	staff mem	ber as well	as guardian
Date	# of Pills Received Date & Initial (Staff & Guardian)	Time of Administration	# of Pills Remaining	Initials	Comments	
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Staff Signatures					Initials	Date