Medication Administration Record

Childs name: ..... Date of birth: .....

To be completed by the parent/guardian								To be completed by the educator when administered							
Name of medication	Last administered		To be administered (or circumstances to be administered)		Dosage to be administered	Method of administration	Signature of parent/Guardian	Medication administered		Dosage Administered	Method of admini-stration	Name of educator administering	Signature of educator administering	Name of witness	Signature of witness
	Date	Time	Date	Time				Date	Time						