

Monthly Medicine Record

Child Name: _____ Month _____ Year _____

Child Known Allergies:

Parent Permission to give medicine: I give my permission for the child care business to give the following medicine(s) to my child.

| | | | | | | | |
|--|-------------------------------------|--------------------------------|-----------------------------|---|------------------------------------|------------------------|--|
| Date: | Parent Signature Giving Permission: | Name of medicine on the label: | Medicine dose on the label: | Time of day medicine is to be given at child care: ¹ | Route of medicine as on the label: | Possible side effects: | Required storage: <input type="checkbox"/> Refrigerate <input type="checkbox"/> Refrigeration not required |
| <input type="checkbox"/> Medicine is doctor approved and doctor authorization form on file at child care | | | | | | | |
| Reason medicine needed: _____ | | | | | | | |
| Special instructions for giving medicine: ² _____ | | | | | | | |
| Beginning date for medicine: _____ | | | | | | | |
| Ending date for medicine: _____ | | | | | | | |

| | | | | | | | |
|--|-------------------------------------|--------------------------------|-----------------------------|---|------------------------------------|------------------------|--|
| Date: | Parent Signature Giving Permission: | Name of medicine on the label: | Medicine dose on the label: | Time of day medicine is to be given at child care: ¹ | Route of medicine as on the label: | Possible side effects: | Required storage: <input type="checkbox"/> Refrigerate <input type="checkbox"/> Refrigeration not required |
| <input type="checkbox"/> Medicine is doctor approved and doctor authorization form on file at child care | | | | | | | |
| Reason medicine needed: _____ | | | | | | | |
| Special instructions for giving medicine: ² _____ | | | | | | | |
| Beginning date for medicine: _____ | | | | | | | |
| Ending date for medicine: _____ | | | | | | | |

| | | | | | | | |
|--|-------------------------------------|--------------------------------|-----------------------------|---|------------------------------------|------------------------|--|
| Date: | Parent Signature Giving Permission: | Name of medicine on the label: | Medicine dose on the label: | Time of day medicine is to be given at child care: ¹ | Route of medicine as on the label: | Possible side effects: | Required storage: <input type="checkbox"/> Refrigerate <input type="checkbox"/> Refrigeration not required |
| <input type="checkbox"/> Medicine is doctor approved and doctor authorization form on file at child care | | | | | | | |
| Reason medicine needed: _____ | | | | | | | |
| Special instructions for giving medicine: ² _____ | | | | | | | |
| Beginning date for medicine: _____ | | | | | | | |
| Ending date for medicine: _____ | | | | | | | |

Parent permission to contact pharmacy and physician: I give my permission for the child care business to contact my child's pharmacy and physician should questions arise or a situation occur that involves my child and the medication.
 Parent Name (print): _____ Parent Signature: _____ Date: _____

¹The time of day for the medicine needs to be consistent between home, child care and other programs where the child is located like school. Ask the parent when the medicine is given at home so medicine doses may be evenly spaced for maximum benefit.

²The medicine may need to be given before meals, after meals, with food, with a specific liquid (water or milk). All instructions should be written on the medicine label or instructions. When in doubt, call the pharmacy where the prescription medicine was dispensed.

Attach
Child
Photo
Here

Monthly Medicine Record

Child Name: _____

| Month Year | Medicine, Dose and Route Example: Amoxicillin 250 mg., 1 teaspoon, orally | Time of Day ↓ 10 am | Day of Month | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---------------|---|-------------------------------|--------------|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| | | | 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 | | | | | | | | | | | | | | | | |
| | | | * | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

*Place your initials in the box showing the medicine was given. Use an "A" when a child is absent. Use an "O" when medication is not given for any reason. Document the reason the medication was not given and document that the parent was informed.

Instructions for using Medicine Record:

- **First Column:** Record the medicine name, dosage, and route.
- **Second Column:** Record the time(s) of day the medicine is to be given at child care. If the medicine is given more than one time a day, use a separate row for each time of day the medicine is to be given.
- **Third – Last Column:** The person who measures and gives the medicine must place the person's initials in the appropriate **row** (for time) and **column** (for date) that the medicine was given. Use columns numbered from 1-31 for the date. The person who measures the medicine dosage is the only person allowed to give the medicine.

Call the Healthy Child Care Iowa talkline 1-800-369-2229 to order free copies of this form.