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: ☐ Refrigerate ☐ Refrigeration not required
☐ 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: ☐ Refrigerate ☐ Refrigeration not required
☐ 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: ☐ Refrigerate ☐ Refrigeration not required
☐ 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:_________________

[1]The 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.
[2]The 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.

January 2007

Monthly Medicine Record

Attach Child Photo Here

Child Name:_____

Month_____
Year_____

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

*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.

Iowa Poison Control Center: 1-800-222-1222