Knox Kids Co. Medication Record

Name of child:_____Date:_____

Date meds prescribed: _____

Name of prescribing physician: _____

Physicians Telephone number: _____

Medications purpose: _____

Name of medication: _____

Dose: _____

Time to be given: _____

The child has received _____ doses at home and the children's reaction to the med were _____

I _____ authorize Knox Kids Co. to administer _____ to my child according to the instructions above.

Last dose to be given at Knox Kids Co. will be:_____

Date	Time	Amount	Prep initials	Admin initials	Parent signature

Initials:_____ Signature:_____

Initials:_____ Signature:_____

Initials:_____ Signature:_____

Initials:_____ Signature:_____