**Medical – Medication Record**

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| To be completed by the parent/guardian | | | | | | | | To be completed by the educator when administered | | | | | | | |
| Name of Medication | Last Administered | | Administer (date/time or circumstances) | | Dosage to be administered | Method of Administration | Signature of parent | Medication Administered | | Dosage administered | Method of Administration | Name of educator administering | Signature of Educator Administering | Name of witness | Signature of witness |
| Time | Date | Time | Date |  |  |
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Child’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_