***Childs Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Month: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Prescribing Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address/Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prescribed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prescribed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prescribed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prescribed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\* Document the time and initial the appropriate space each time medication is administered.*

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| **Medication** | **Dosage** | **Frequency** | **1**  Time/Initials | | **2**  Time/Initials | | **3**  Time/Initials | | **4**  Time/Initials | | **5**  Time/Initials | | **6**  Time/Initials | | **7**  Time/Initials | | **8**  Time/Initials | |
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| **Medication** | **Dosage** | **Frequency** | **9**  Time/Initials | | **10**  Time/Initials | | **11**  Time/Initials | | **12**  Time/Initials | | **13**  Time/Initials | | **14**  Time/Initials | | **15**  Time/Initials | | **16**  Time/Initials | |
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| **Medication** | **Dosage** | **Frequency** | **17**  Time/Initials | | **18**  Time/Initials | | **19**  Time/Initials | | **20**  Time/Initials | | **21**  Time/Initials | | **22**  Time/Initials | | **23**  Time/Initials | | **24**  Time/Initials | |
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| **Medication** | **Dosage** | **Frequency** | **25**  Time/Initials | | **26**  Time/Initials | | **27**  Time/Initials | | **28**  Time/Initials | | **29**  Time/Initials | | **30**  Time/Initials | | **31**  Time/Initials | |  |
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*\*Remember to Document: (1) Child’s full name; (2) Prescribing physician; (3) Medication name, strength, and dosage; (4) Date and time medication was administered; (5) Name and signature of person administering medication; (6) Child’s refusal to accept medication; (7) Reasons for administering the medication*

***\* Each set of initials should have a corresponding signature.***

**Signature(s) of person(s) administering medication**:

**Signature(s) of Case Manager:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Case Manager reviewed for accuracy in home on:*** *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Date & Initials***