EFM RESPITE CARE
MEDICATION ADMINISTRATION LOG

Child's name: _____ DOB: _____

Provider's name: _____

Date	Name of Medication/Treatment	Start Time	Stop Time	Dosage Amount	Child's Response / Notes

Provider signature: _____ Date: _____

Parent signature:_____ Date:_____

Things to Remember:

□ Verify that the child's name on medication and the child receiving medication are the same
□ Read and understand the label instructions
□ Observe and report any side effects
□ Document administration
□ Over-the-Counter medication cannot be administered without physician's written approval.