Health Care Plan Medication Record

Date:……

Child's Name:…….

Child's Date of Birth and Age:……

Name of Medication: **Expiry Date:**	
Time(s) at which medication was administered:	
Dosage:	
Printed name of staff member who gave medication and witness:	
Signature of staff member who gave medication and witness:	

TO BE FILLED IN WHEN PARENT/CARER IS INFORMED:

Parent/Carer name and signature:	
Senior staff member on Duty printed name & signature:	
Person in Charge (if different) printed name & signature:	

ATTACH THIS DOCUMENT IN THE MEDICATION RECORD BOOK ON COMPLETION.

Completed:4/9/17

To be reviewed: 4/9/18