



Medication Record: Short Term

Child Details

Name:	Date of Birth:
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Medication Details

Type:	Expiration Date:
Dosage Required:	Frequency:
Last Dose Administered:	I confirm that my child has had this medication before with no reaction. <input type="checkbox"/>

Parent / Guardian Authority: _____ Date: _____

Medication Administered

Date:	Time:	Administrator:	Supervisor:	Parent: