**OCFS-LDSS-7004** (5/2014) FRONT

NEW YORK STATE

OFFICE OF CHILDREN AND FAMILY SERVICES

# Log of Medication Administration

* Caregivers may use this form or an approved equivalentto document medications administered in the day care program.
* Documentation must be kept with the child’s written medication consent form.
* Any doses of the medication listed below not given must be documented.

|  |  |  |  |
| --- | --- | --- | --- |
| **CHILD NAME:** |  | **MEDICATION:(including dose)** |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| COMPLETE FOR ALL DOSES GIVEN | | | | | **COMPLETE WHEN SIDE EFFECTS ARE NOTED** | | **COMPLETE FOR ‘AS NEEDED’ MEDICATION ONLY** | |
| Date Given  (M/D/Y) | Dose | Time (AM or PM) | | **Administered by**  (full signature) | **Any Noted Side Effects** | **Were parents notified of side effects?** | **For “as needed” medication – write the symptoms the child exhibited that necessitated the need for the medication** | **Were parents notified “as needed” medicine was given** |
|  |  |  | AM  PM |  |  | Yes  No |  | Yes  No |
|  |  |  | AM  PM |  |  | Yes  No |  | Yes  No |
|  |  |  | AM  PM |  |  | Yes  No |  | Yes  No |
|  |  |  | AM  PM |  |  | Yes  No |  | Yes  No |
|  |  |  | AM  PM |  |  | Yes  No |  | Yes  No |
|  |  |  | AM  PM |  |  | Yes  No |  | Yes  No |
|  |  |  | AM  PM |  |  | Yes  No |  | Yes  No |
|  |  |  | AM  PM |  |  | Yes  No |  | Yes  No |
|  |  |  | AM  PM |  |  | Yes  No |  | Yes  No |
|  |  |  | AM  PM |  |  | Yes  No |  | Yes  No |
|  |  |  | AM  PM |  |  | Yes  No |  | Yes  No |
|  |  |  | AM  PM |  |  | Yes  No |  | Yes  No |
|  |  |  | AM  PM |  |  | Yes  No |  | Yes  No |
|  |  |  | AM  PM |  |  | Yes  No |  | Yes  No |
|  |  |  | AM  PM |  |  | Yes  No |  | Yes  No |
|  |  |  | AM  PM |  |  | Yes  No |  | Yes  No |
|  |  |  | AM  PM |  |  | Yes  No |  | Yes  No |
|  |  |  | AM  PM |  |  | Yes  No |  | Yes  No |

**OCFS-LDSS-7004** (5/2014) REVERSE

NEW YORK STATE

OFFICE OF CHILDREN AND FAMILY SERVICES

# Log of Medication Administration

**Complete this section if the above medication was not given as written on the child’s written consent form**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date Not Given** | **Description of reason why medication not given** | **Parents notified** | **Signature of Provider** |
|  |  | Yes  No |  |
|  |  | Yes  No |  |
|  |  | Yes  No |  |
|  |  | Yes  No |  |
|  |  | Yes  No |  |
|  |  | Yes  No |  |
|  |  | Yes  No |  |
|  |  | Yes  No |  |
|  |  | Yes  No |  |

|  |
| --- |
| Notes: |