Alphapointe Prescription Medication Log

(Please fill out one form for each kind of medication)

Child's Name

I give permission to Alphapointe staff to administer the following medication to my child. I will not hold my provider liable in the event of reactions or complications arising from my child receiving this medication.

Parent Signature

Name of medication:

Reason for medication:

Is this medication for the child as needed? Yes ☐ No ☐

Start Date:

Finish Date:

Times for each dosage: (Please specify the exact time or mealtime in the below chart)

#	Moring (Breakfast)	Noon (Lunch)	Night (Dinner)	Amount per dose
1				
2				
3				
4				
5				

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The chart below is to be filled out by the Alphapointe Staff Nurse.

Dosage Log				
Date	Time	Dose	Signature/initial	Comments

Special Notes or Comments: