CENTRAL MISSISSIPPI, INC., HEAD START
HEALTH SERVICES
DAILY RECORD OF PRESCRIBED MEDICATION ADMINISTRATION

Child's Name _____ **Center** _____

Date _____

Time	Name of Medication	Amount Given

Comments (vomiting, spit medication out) _____

_____

_____

_____

Signature of Staff Administering Medication: _____

Assurance of Confidentiality: All of the information you provide helps us to deliver services most appropriate for your family needs. You may prefer not to share some information with us. However, some information is required to determine eligibility. All information is held in strict confidence.
(Revised 06/05)